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How the Hospital May Justify the Public's Confidence

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THERE exist to-day certain conditions affecting our people that leave no true friend of medicine and the public without concern. Two of these are now most critical: first, the great increase in the number of pseudo-physicians, and, second, the mounting cost of medical care. To my mind the correction of both of these lies in the same means and in measures in which the hospitals can have a large part.

The quack is no new excrescence upon our social structure. A medieval writer tells us of those who "have Galen and Hippocrates continually in their mouths . . . make their hearers stare at long, unknown and high sounding words. . . . They have only two maxims which they never violate: 'Never mind the poor; never refuse money from the rich.'" The Perkins' tractor, the blue light craze and the Abrams' diagnostic machine are known to us all. We realize that as long as ignorance persists and emotion supersedes judgment, the public will be a prey for the dishonest. It is the increase of this evil in a period of supposed greater public enlightenment that alarms us.

There are so many chiropractors, naturopaths, cancer quacks, faith healers, electropaths, Chinese herbalists, bone setters, electric belt adherents and buckeye specialists, to say nothing of Lydia

Pinkhams and devotees of patent medicine, that the trained physician must almost wear spurs on his elbows. Knowing the great advances in medical science, the great discoveries of our investigators, the pathology of disease and the means of avoiding it, we are astounded that the public seems so bereft of common sense. We forget, however, that common sense is not common, but uncommon.

Education Is the First Need

What is our responsibility in face of this evil? The parable of the Good Samaritan tells us that the traveler to Jericho fell among thieves who robbed him of his raiment and left him bruised and bleeding by the wayside. I submit that the Good Samaritan did only half his duty when he bound up the traveler's wounds; he should also have warned others of the dangers of the road. But how may we prevent the exploitation of the patient by the unscrupulous charlatan and the well intentioned but ignorant faith healer? Legal restriction can go no faster than public education. We have had an example of this in our recent attempt to control by law the sale of intoxicants.

In the present state of public education, any attack by physicians is misunderstood and attrib-

uted to jealousy and factional discord, a pathetic commentary on the general absence of real knowledge of the great achievements of modern medicine. We must therefore disabuse our minds of the vain hope of quick results and depend upon the general education of the people; and in this the hospital and not the physician should take the larger part.

Science Versus Personal Service

The second tendency that gives us great concern is the complaint of the patients as to the increased cost of medical care. It will serve no good purpose for us to ignore the criticisms and demands of the public, no matter how unjustifiable. They demand on the part of physicians more personal service and less cold science; more constructive thought as to means of obtaining accurate diagnosis at a minimum cost. They demand on the part of hospitals kindly attention, with privacy and adequate service at less expense. They demand on the part of nurses adequate moderately priced personal attention.

I do not deny that a few disreputable members of our profession are guilty of excessive charges and that the cost of individual diagnostic service under the present methods may be excessive, though justified. Although it is infrequent, the first should be met by condemnation and stern action, and the second by a constructive rearrangement of service and mutual study by the physicians and the hospitals. As to the charges for hospital and nursing service, the public remembers its generous support of institutions that care for the sick and forgets the increased cost of service in all phases of economic life. It is ignorant of the necessary adjuncts to hospital service, such as chemical and x-ray laboratories, social service and free beds, and consequently represents an expense it had not anticipated. In face of this resentment, the hospitals should give intensive study to the possibility of a partial reduction of hospital charges and justify by public education the part remaining.

I do not forget that every hospital is earnestly striving for this end. Criticism is far from my intention. I intend rather to support the hospitals' endeavor to give adequate sympathetic service at moderate expense. In this spirit may I mention that there is a public demand for more small, simply furnished, private rooms equipped with toilets and not baths, rooms that give privacy without luxury; for more investigation of group nursing service with the hope of providing adequate service at less expense; for fewer campaigns for elaborate entrances and marble halls, and more for the endowments of laboratory and

social service departments. Hospital architects must give more study to the problem of moderately priced buildings constructed to permit simplified nursing service, private rooms that are unostentatious and the economical preparation and serving of foods. The private patient should be freed from the overcharge incidental to the care of free patients, who should be supported exclusively by specific endowments.

Community needs should be thoroughly investigated before new hospitals are established. The number of beds necessary for efficient and economical administration and the quality of service to be rendered should be the deciding factors rather than the urge of religious or factional pride or prejudices.

More study should be given to dividing among the hospitals of a community the expenses and sharing the benefits of the special departments, such as radiology, pathology and social service, and other technical and professional activities.

The well informed, however, know that when all this has been done, the demands for scientific and efficient service will still require a charge greater than the ill-informed public expects. Therefore, along with this intensive study of medical economic efficiency must go the education of the public about scientific medicine and its requirements.

Thus far I have summarized the ramifications of these two urgent problems and emphasized that the only solution of both lies in a more general appreciation of the advances of scientific medicine. To the hospital will fall in large part the duty and opportunity of initiating and supporting this educational movement. Before we consider the means by which this may be attained, it is advisable to analyze our relation to the public.

How Relationships Have Changed

Hospitals originated in Egypt and Greece as a part of a universal state religion, and later developed into the great charity institutions of Europe as an expression of sympathy of the people as a whole for the sick poor. We have restricted their scope, and developed the modern type of hospital initiated and supported by various sects for both private and free bed patients. The charity hospital in most instances has become the responsibility of the impersonal municipal governments. Thus the hospital has withdrawn itself from the support and sympathy of the public as a whole, and the individual, unless a member of a particular group, has lost interest, except at times of personal illness. The gap was widened by the development of medical science in hospital service. The average man can understand and

appreciate sympathy for the unfortunate; but science with its bacteria, its aseptic operating rooms and its elaborate technique leaves him cold and destroys his sense of personal relationship. Hospital staffs and organizations engrossed in the intriguing problem of keeping abreast of the startling progress of science fail to realize that they are gradually losing contact with the everyday citizen.

Winning the Public's Support

It should be the endeavor of the hospitals to regain this one time general public sympathy and support. Praising ourselves and boasting of our victories without constructive action will be of no avail. We cannot expect like Joshua to march seven times about this modern Jericho, blow our own horns and have the walls of ignorance fall. If hospitals are ever to regain this lost general interest, if they are to become an effective unit in the education of the people as to the merits of scientific medicine, they must minimize sect and group domination, cease to be an expression only of institutions to which patients should be sent when sick and become centers for the prevention as well as the cure of disease. They must submerge their individuality, sect ambitions and interhospital jealousies in the life of their communities. They must cooperate actively with all community health movements, initiate and associate with themselves all programs for the prevention of disease and become the center for all activities conserving the well-being of our people. In the hospitals should be established the executive offices for the various organizations devoted to infant welfare, prenatal education, prevention of tuberculosis, blindness, heart disease and all other public health agencies.

The various campaigns must be developed and supported by interhospital affiliation, with mutual understanding, without jealousy and in an earnest endeavor to make hospitals as a group, and not a certain hospital, synonymous in the mind of the everyday citizen with all expressions of conservation of health, all campaigns for the prevention and eradication of disease and all programs for the dissemination of knowledge as to the great advances and victories of scientific medicine.

The educational program is not the least important. By common action and support, public lectures should be instituted upon every phase of health and disease. For these lectures, well informed laymen and physicians should be drafted, the minister and the priest, the publisher and the publicist, the leaders of women's clubs and the labor organizations, the health insurance expert and the health officers of cities.

Public exhibits demonstrating the cause and cure of disease, the sources of contagious diseases and how to combat them, the treatment of emergencies and the many other subjects of vital interest to the layman should be a part of the campaigns. The national hospital organizations should prepare exhibits to be loaned to every hospital group. These lectures and exhibits should not be for the adherents and supporters of any particular hospital, but should be initiated by common hospital action in the interest of the whole community, advertised by the press and the pulpit and of such a nature as to appeal to the general interest.

There is nothing that would arouse and maintain interest in hospitals more than the initiation and support of clinics for the yearly health examination. Again, however, the clinic should not be exclusively in the interest of a certain hospital staff, but it should be inaugurated and supported by the profession as a whole with the hospital providing the facilities. Such clinics held at stated times and participated in by physicians designated by the profession, if carried out ethically, would render a service hardly possible by the individual physician. They should be organized after the manner of the examining boards during the great war, where with physicians assigned to examine for each specialty, scores could be cared for in a single evening and an efficient examination made at the same time.

If hospitals will thus submerge themselves in the life of their communities, serve disinterestedly the cause of public health and the dissemination of scientific knowledge and work unselfishly with each other, quackery will be eradicated, anxieties as to financial needs will cease and the hospitals will have justified the support of a generous public.¹

Hospital for Chiropractors May Be Established in Oklahoma

Gov. William H. Murray of Oklahoma has announced that he probably will propose to the next legislature a bill to construct a state owned and operated hospital open to all forms of treatment and for use of chiropractors and other nonmedical practitioners, according to a recent news release.

This announcement followed action of the board of regents of the University of Oklahoma in refusing to permit chiropractors in the hospital, which is operated in conjunction with the medical school.

¹Read at the Hospital Standardization Conference of the American College of Surgeons, New York City, October 12-15.



Bronze Gates, hung in a carved doorway of Italian Renaissance design, lead through an open patio to the waiting room of the W. I. Cook Memorial Hospital, Fort Worth, Tex.

A Perfect Idea That Achieved a Perfect Culmination

By ANGELICA P. DIDIER

Superintendent, The W. I. Cook Memorial Hospital, Fort Worth, Tex., and
R. E. NAIL, JR.

EVEN when it was still an idea without a definite chance of realization, the W. I. Cook Memorial Hospital, Fort Worth, Tex., fared better than many hospitals, for it was a perfect idea. The donor, the physicians, the architect and the technicians who turned the idea into an actuality attempted to keep the realization as close to the original conception as possible. Scarcely a tile was laid without deliberate and purposeful planning, because the builders aimed at completeness rather than size. The result of their labors is an efficient and excellent hospital plant, housed in a

pleasing structure and successfully performing the charitable duty for which its donor specified its use, the care of sick working girls and women.

Mrs. W. I. Cook, who built the hospital as a memorial for her husband and daughter, saw the need of an institution that might be of definite assistance to women who, though not necessarily poverty-stricken, work for their living and lack money enough to obtain the proper medical care. She was particularly anxious that a hospital giving such service should be as free as feasible from the impersonal atmosphere that usually pervades a char-



The dining room for the personnel where food is served cafeteria fashion is finished in soft colored Spanish tile.



This view of a corner of the patio shows interesting details of construction—the gracefully arched ceiling, the wall niche with its bronze statue and the wrought iron lantern.

ity organization. For that reason, no room in the building contains more than three beds, and all patients are treated as private patients. The hospital also has rooms for pay patients.

How the Ideal Was Realized

Set high upon a hill overlooking the central part of the city, withdrawn behind a tree shaded lawn, the building, constructed of Indiana limestone and topped by a green tile roof, suggests something of the kindness, the gentleness and the sturdiness of the old Southwest. Mrs. Cook, owner of a Western ranch, had always wanted to build such a hospital, but it was not until oil was discovered upon her lands that she could realize her dream. Therefore, despite the fairylike circumstances of its birth, the hospital partakes also of the industry

and the progressiveness of the new Southwest.

One comes into the building through bronze gates, hung in a carved doorway of Italian Renaissance design. On the floor, as a symbol of the West that made the hospital possible, is a bronze "tumbling T," the brand used upon Mrs. Cook's ranch. Passing on, one walks through an open patio into the reception room, the long hall, which serves as a waiting room for patients of both the hospital and the clinic. It is finished with travertine walls, heavy walnut beams across a gold ceiling and a floor of brown and white marble. The furniture, which consists of two old carved Italian chests, leather couches and chairs, shaded lamps, portraits and tall brass candlesticks, gives it the air of a beautiful home, rather than of a hospital waiting room.



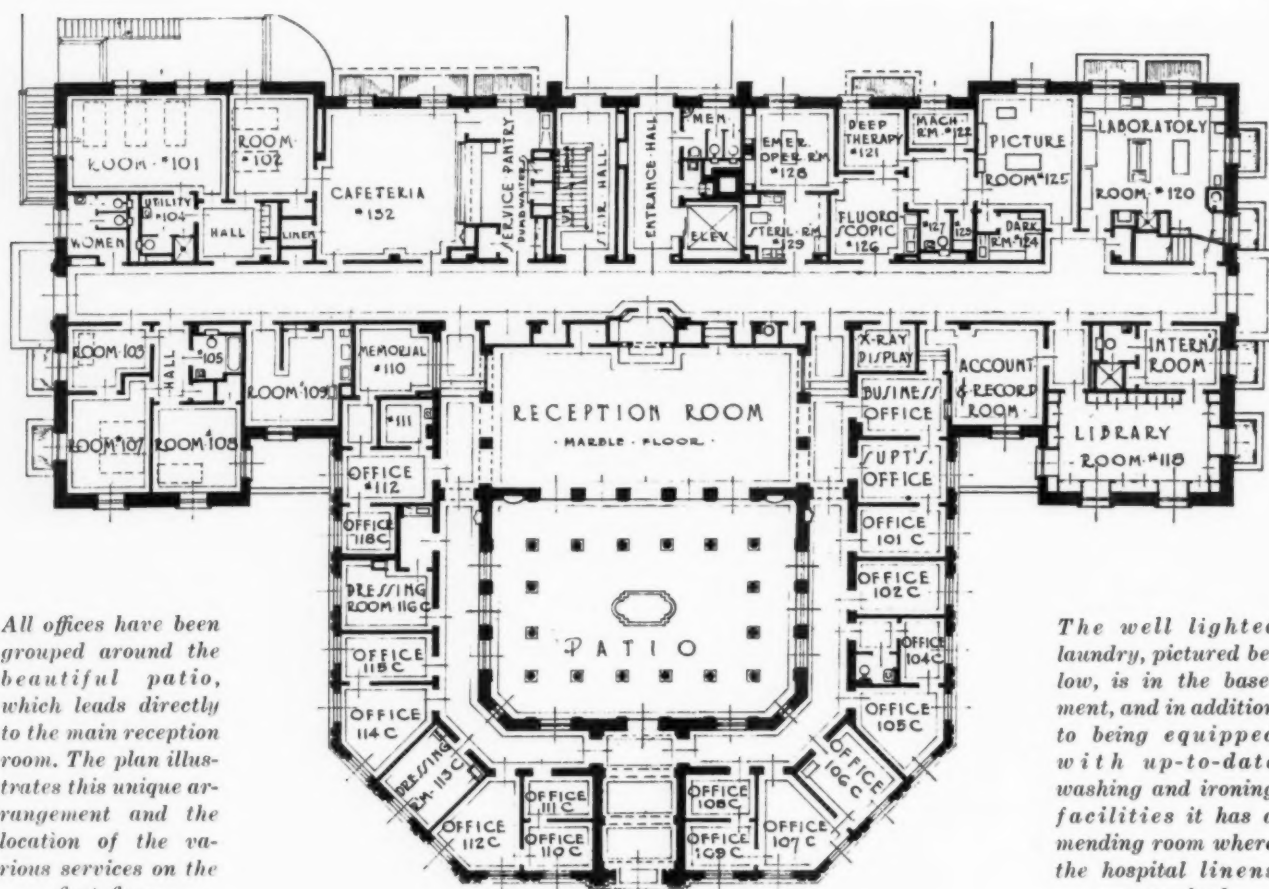
On the ground floor, withdrawn from both the activity and the atmosphere of the hospital, is the medical library, a beautiful room with paneled walls, and Jacobean furniture.

The principal unit of the building is three stories high. Attached to the front is a one-story structure, built around three sides of the patio and containing the offices of the staff physicians. The main portion of the ground floor houses, in addition to the reception room, the administrative office, the laboratory, the x-ray department, the emergency operating room, the treatment rooms and the rooms equipped for physical therapy. Here also is the medical library, a beautiful walnut paneled room, with book shelves in between the panels, furnished with Jacobean chairs and tables, red leather armchairs and lamps with parchment shades. The curtains are of hand blocked linen chintz in soft colors. The library is withdrawn from both the activity and the atmosphere of the hospital.

The dining room in which food is served for the hospital personnel in cafeteria fashion is finished in soft colored Spanish tile.

The second floor is devoted principally to patients' rooms. The walls and furnishings are done in light colors—ivory, green and French gray, and the floors are of noiseless composition rubber. At the head of each bed there is provision for the signal call light system, an emergency bell, a telephone and a radio. All bedrooms have private bathrooms, tiled to correspond in color with the room. Each of these bathrooms has running ice water, built-in cabinets for utensils, shower baths and tubs and bedpan washers. The faucets at the washstands can be turned away from the basin, making it easy to fill pitchers and flower vases.

The roof of the one-story clinic building is on the



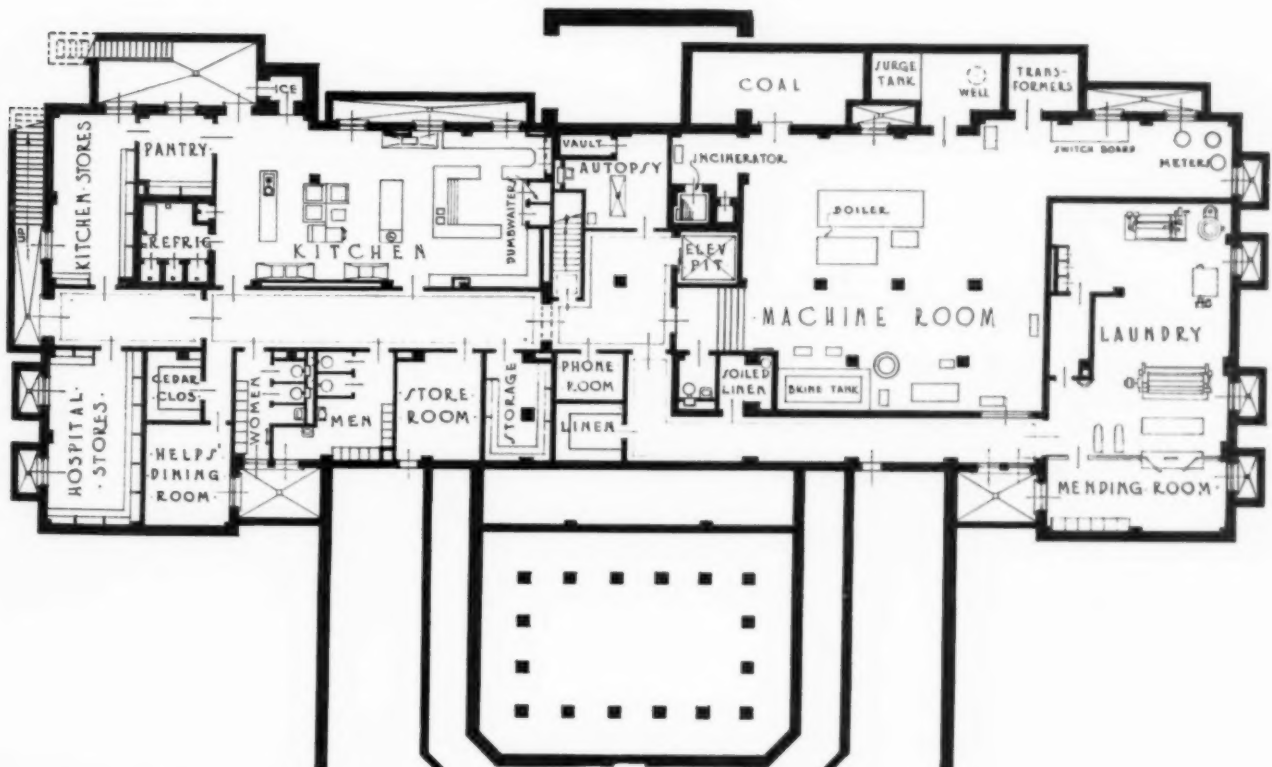
All offices have been grouped around the beautiful patio, which leads directly to the main reception room. The plan illustrates this unique arrangement and the location of the various services on the first floor.

The well lighted laundry, pictured below, is in the basement, and in addition to being equipped with up-to-date washing and ironing facilities it has a mending room where the hospital linens are repaired.





Every inch of basement space has been effectively utilized. Some of the appetizing food prepared in the main kitchen, which is in the basement, is shown in the upper picture. The plan below shows the relation of the kitchen to the other departments located in the basement and their convenient arrangement.



same level as the second floor and is made into a tiled sun deck, upon portions of which overhanging trees cast a pleasant shade. Since the hospital is withdrawn from the smoke and dirt of the city, the sun deck has been of great value to the patients. Both beds and chairs can be rolled upon it from the enclosed sun room with which it directly communicates. The sun room has windows that permit the passage of the ultraviolet rays of the sun.

In addition to bedrooms, the third floor contains

tered doors having been rejected for several reasons, a door with two wooden transoms, a small one at the top and a larger one at the bottom, was found most suitable, since it permits a free circulation of air and at the same time assures privacy to the occupant of the room.

The physical plant is practically self-sufficient. The central heating system, the high pressure boilers and the incinerator are all in the basement and are run by gas. A laundry and sewing room are in the basement as well as other facilities.



The laboratory is equipped to make all the routine tests that are necessary as an aid to correct diagnosis.

the operating suite, made up of three operating rooms, physicians' dressing and sitting rooms, the sterilizing apparatus, the supply rooms and the nurses' workrooms. The floors and walls of the entire suite are of green and orchid tiles.

In designing the structure, the architect, Wylie Clarkson, gave special thought to adapting the building to the Texas climate. Each of the three floors has a wide central hallway which runs the length of the building and ensures a current of fresh air. Every room has a ceiling fan. Venetian blinds at all windows have proved a decided advantage in subduing the sun's glare without cutting off the breezes. The doors throughout the hospital are of walnut, two inches thick, and those opening into patients' rooms are of a unique design, also dictated by a consideration of the climate. Shel-

All refrigeration is done by an ice plant. Electricity comes from the city's public utilities, but the water supply is privately owned, since artesian wells some 400 feet deep are directly beneath the building and provide an ample supply of soft water. This comes from the earth warm, but is rapidly cooled by a cooling system.

All food is distributed to patients through a central food service. The main kitchens and the office of the dietitian are in the basement. Dumb-waiters carry the trays to the floors and also to the dining room of the personnel. The floor maids carry the trays to the patients. Each diet kitchen has its own electric ice box.

The hospital has a closed staff of physicians and a trained dietitian. It employs only graduate nurses.

Lightening the Burden of the Hospital's Free Load

THROUGHOUT the entire hospital field, administrators for months past have anticipated in the present winter a time of financial worriment because they have felt that, in a degree even greater than during the past year, their institutions will be expected to bear exceedingly heavy free load burdens.

Indeed, in some instances it has seemed almost impossible to meet the bona fide relief requirements in communities where unusual unemployment conditions are to be found. Thoughtful men and women everywhere are considering methods by which the distress of the unemployed may be alleviated. Moreover, in many places community chest drives, for this year at least, are being merged with efforts to relieve those who are unable to obtain work.

At the recent convention of the American Hospital Association, there was submitted a resolution for adoption which crystallized the beliefs of lay as well as of professional workers with regard to the absolute necessity of including as a part of the general welfare problem the care of the unemployed when they become ill. In order to ascertain the opinions of leading hospital executives on this matter, several were asked to suggest means whereby the hospital may obtain relief in carrying its free load.

THE MODERN HOSPITAL, therefore, believes that it is rendering a distinct service to the field in printing the opinions of a number of administrators on this subject. Incidentally, it will be noticed that not only are those who participate in this symposium outstanding figures in the hospital world but that all have occupied, and one at present occupies, the office of president of the American Hospital Association.

How Leaders View the Situation

The opinions expressed by these eminent men appear to indicate: (1) that all hospitals should bear as great a free load as their finances will permit; (2) that it is not fair to the community and to the hospital to permit the institution to ruin itself financially and to destroy its further service possibilities by endeavoring to meet an impossible economic requirement; (3) that the hospital must and should demand of tax collecting

agencies per diem per capita payment for free work when its financial possibilities have been exceeded.

It will also be noted from these opinions that the contributors to this symposium unanimously approve of the resolution in substance, if not in form, which was presented at the American Hospital Association on October 1, 1931, a copy of which is presented with this article. Hospitals generally throughout the field which are struggling to bear an inordinate free load may do well to heed the advice given here.

*L. A. Sexton, M.D., Superintendent,
Hartford Hospital, Hartford, Conn.*

Hospitals are the most difficult of all organizations to budget, for the reason that no one can anticipate what demands are to be made upon them from year to year. Business organizations have their records with their percentage of increase or decrease in the volume of their output and upon these records they can easily approximate what may be expected in any given year. But hospitals, while the volume of work done may not vary greatly over a given period, cannot foresee when epidemics may come that may largely increase the amount of work required of them. When the public which builds and supports these institutions makes a demand for the care of unusually large numbers of patients, the hospital has no choice in the matter; it must meet these demands as best it can.

Never before, we are told, has a depression lasted as long as the present one. Yet, according to the law of averages, better times and less unemployment are long overdue. Hospitals, however, cannot base their hopes on any improvement in conditions for the coming winter and must expect to increase the amount of free work.

The amount of free work any hospital should attempt under conditions such as we now have should depend entirely on the hospital's income from all sources. The moment that this income is exhausted the community should be told of the existing conditions and every day of free treatment given afterward should be paid for by some sort of community fund. Whether help comes through the community chest, private philan-

Doctor Doane's Resolution

WHEREAS, the privately maintained hospital throughout the field has been asked during the past year and will no doubt in a greater measure during the coming winter be expected to carry an immoderate and unusual burden of free care, and

WHEREAS, because of factors directly connected with the present economic condition of the country, these institutions are wholly unable to bear this load, and

WHEREAS, in many places a community drive has been carried on for the provision of funds for unemployment relief and the hospital has not adequately shared therein, and

WHEREAS, the care of the unemployed sick has not been but should be classed as a definite part of unemployment relief, therefore be it

RESOLVED by the American Hospital Association in convention assembled, that it is the firm conviction that the hospital should receive from such drives a generous appropriation to assist in rendering medical care to the unemployed when ill. It is further

RESOLVED, that when the free load expected of the hospital becomes too great, that the private institution is morally and ethically justified in demanding of tax collecting agencies, reasonable per capita per diem recompense therefrom for the care of what would otherwise be public hospital cases.—*Presented to the American Hospital Association at Toronto, October 1, 1931.*

thropy or taxation, it matters little, so long as the patients get the care and the hospitals are paid for the cost of the service.

Hospitals are community projects. They are created and supported by the public. Consequently, the public is entitled to all the facts relating to their financial condition and management.

Advertise the needs of your hospital just as you do the needs of all other social agencies.

Barring epidemics, we know that one out of every ten persons for whom we are making provision will have to be hospitalized during this winter for a period of three weeks. With these facts before the public, there should be no question about provision being made to include hospital costs in the funds raised by every community.

There is no reason to expect that private philanthropy is going to continue to carry the enormous load it has carried in the past. The time has come when the public should bear its share of the cost of the care of public charges. Their care is just as legitimate a burden for taxation as are our schools, our police and our fire departments.

*Paul H. Fesler, Superintendent,
University of Minnesota Hospitals, Minneapolis*

The amount of free service the private hospital is able to give depends entirely upon the income. It should limit its free work to the amount of surplus from other sources. It is clear that one of the most important objectives of hospitals at this time is to keep the cost at a reasonable level for those who do pay. I have never thought it proper for the private patients to pay for the care of the poor in any hospital unless they were extremely wealthy patients.

Tax collecting agents or community funds should subsidize private hospitals for all free work that is done for the poor of a particular community. Most hospitals will lose enough on the so-called part-pay patients to absorb all of the surplus that is received from those who do pay in full.

About the only way the free load can be lightened is for the influential members of the hospital board, who are more than likely taking part in community drives for funds for the unemployed, to emphasize the medical side of the question and point out that to prevent the spread of disease is essential to alleviate certain problems that go hand and hand with unemployment.

The resolution passed at Toronto is vitally important and should be passed on to all the officers of community funds.

Of course, we must realize that we are also dealing with a few undeserving, strictly commer-

cial private hospitals. They should not be permitted to receive a share of these funds unless it is distinctly understood that they are going to take an active interest in the medical problems of the community and that the money they receive will not be used to reimburse them for losses resulting from bad management.

Hospitals must face conditions as they are. They must not, as has been done in some communities, take unfair advantages of conditions as they exist at this time.

*A. C. Bachmeyer, M.D., Superintendent,
Cincinnati General Hospital, Cincinnati*

From the information I have received, it would seem that private hospitals must gauge the amount of free service they render by their financial ability to supply such service. I do believe, however, that they should render the fullest measure of gratis and part-pay service their financial status will permit. Any increase in the percentage of free work they are doing must depend upon their ability to obtain additional financial support from their contributors.

In our community no additional appropriations have been made for hospital service. Through our department of public welfare, large numbers of men are being given relief in that they are offered employment in various city departments and private agencies, and are paid from funds collected for the unemployed. A number of men are sent to our hospital each day, their services being utilized in such tasks as garden work, window cleaning, janitor service and similar duties—work that otherwise would not be done or that would be performed only in accordance with a slower schedule.

I am definitely in accord with the resolution adopted at the American Hospital Association convention in Toronto and, as already indicated, believe that the treatment of the sick unemployed should be regarded as a definite part of the general unemployment problem.

*L. H. Burlingham, M.D., Superintendent,
Barnes Hospital, St. Louis*

The hospital commissioner of St. Louis recently sent the following letter to the private hospitals of the city: "In surveying the hospital facilities in St. Louis, one cannot help being impressed at the present time with the low rate of occupancy of our private hospitals as compared with the capacity populations reported by the city institutions.

"There is every indication that economic conditions are not going to change sufficiently in the near future to improve our hospital situation materially. To the contrary, it is quite probable that

during the coming winter our municipal hospital facilities will not be equal to the tremendous and continuously growing demand for free hospitalization, with the result that admissions to our eleemosynary institutions will have to be refused to worthy applicants.

"In order to prevent this and having in mind the many empty beds in our private hospitals, it has occurred to me that in this emergency they might be willing to assign some of their ward beds to our patients, at a rate not to exceed the per capita per diem cost of the City Hospital (\$3 a day).

"If the private hospitals of St. Louis can see their way clear to assign for this purpose a sufficient number of beds to provide the much needed relief of the overcrowding of our general hospitals, I shall be more than glad to submit the arrangement outlined to the board of estimate and apportionment for their approval."

If the board of apportionment approves this plan it will certainly be an interesting experiment and well worth watching.

*Malcolm T. MacEachern, M.D., C.M.,
Associate Director, American College of Surgeons*

It is difficult even to estimate the amount of free service the private hospital may be called upon to render under the stress of present economic conditions. We are quite safe in assuming that the demand will be greatly increased and at least double what it has been in normal times.

In conferring with a large number of superintendents in different parts of the United States and Canada I find they are all in accord with this estimate. Some of them, in fact, were of the opinion that there might be no limit to the demand on the average community or private hospital for free service. Apparently a great many private patients who formerly selected more or less superior private room accommodation are now occupying a minimum rate private room or semiprivate ward, whereas the so-called semiprivate or part-pay patient is seeking free service, either in the community or private hospital or in the county hospital. There has been considerable comment, on the West Coast particularly, on the number of former pay patients who are now going to the county hospitals where they can receive free care or care at a low rate. The excellence of some county hospitals in appointments and high grade service is attracting more and more the type of patient who could pay public or semiprivate ward rates in other types of hospitals.

From my experience with and knowledge of a large number of community or private hospitals under survey, I do not believe they can carry more than 10 or 12 per cent free work, and to do this

they really must have an average of 75 per cent bed occupancy. This absorbs the more or less generally accepted custom of providing a 10 or 12 per cent profit on the pay work carried on. It would seem to me unwise for this type of hospital to assume a greater obligation than that of contributing 10 per cent of its earnings for free or charity work without making sure of additional funds for this purpose from some other source.

In my opinion, the community hospital that contributes free service to the unemployed should participate in the funds collected to meet the present unemployment contingency. The hospital or hospitals of the community doing this work should make it known to those who control such funds. In every ethical manner possible they should inform the community of what they are contributing. In making this statement I am including only the extra load of free service they have assumed and not the charity work they would do ordinarily. Even private or community hospitals are expected to make their contribution to the relief of distress in the present economic situation, but the extra load they may be obliged to carry should be compensated for, in great part at least.

Personally, I am in accord with the resolution passed at the American Hospital Association meeting in Toronto recently regarding the treatment of the sick unemployed as a part of the general unemployment problem. We must carefully guard against overloading our hospitals with the countless charity demands that may be placed on them during the next few months.

*Winford H. Smith, M.D., Director,
Johns Hopkins Hospital, Baltimore*

On a logical business basis, the amount of free service a private hospital should render should be gauged by the funds available. If the community is unable or unwilling to supply the funds for additional free service, there is no reason why the hospital should be expected to assume the obligation.

I do not think the hospital should be expected to add to the free work at all before making demands upon tax collecting agencies. As a matter of fact, in my judgment, the hospitals are not receiving the amount of support to which they are entitled from the tax collecting agencies at the present time.

It seems to me that the service the hospital is rendering and will be called upon to render in this emergency is sufficient argument in itself for participation in the Emergency Relief funds.

I heartily endorse the resolution passed by the American Hospital Association. I think it could have been and should have been made stronger.

*F. A. Washburn, M.D., Director,
Massachusetts General Hospital, Boston*

Of course, this is no time for a private hospital to cut down the amount of free service it has been accustomed to give, if it can possibly finance this work or carry it on without incurring too heavy a debt.

If a hospital is in a position to increase its free work, why, of course, that is fine, and such a hospital would naturally gladly do it. The trouble, as I see it, is that many hospitals must diminish the amount of their free work when it is most needed, for two reasons: (1) Their income from private patients has materially lessened, that being the part of the hospital work which often shows a profit; (2) in most instances the treasurer's receipts, both income from invested funds and gifts from benefactors, have also materially decreased.

When a hospital faces a demand for free service it cannot give without incurring a serious indebtedness, then its only recourse, as I see it, is to apply for relief to those agencies that have the money. The private hospital should first of all, I think, try to get a percentage from the funds collected in unemployment drives. To interest those in charge of these funds, it would be necessary to present to them actual figures of income and hospital costs covering a period of years and a statement of the actual increased deficit due to the added free service for the past year and estimated for the coming year.

If that attempt is unsuccessful, or if not enough money is thus obtained, why then the hospital should try to collect the cost of board or at least the ward rate charged from the cities or towns or states in which the patient is resident. If the city or town has anywhere else to send these patients and it is made clear that the private hospital cannot take them in unless they are paid for, I think the money will be produced. The trustees will have to be firm in many instances.

As to the resolution passed at the American Hospital Association meeting, I was in entire sympathy with the thought behind the resolution.

*W. L. Babcock, M.D., Superintendent,
Grace Hospital, Detroit*

The amount of free service independent general hospitals can render in the light of present economic conditions is to be gauged by their endowment incomes. I do not believe that many hospitals are meeting expenses or making profits that they can apply to free work.

The welfare commission of Detroit has been notified by the hospitals of the city that they will cooperate in relief to the extent of their funds. The percentage of work that private hospitals can

apply to this situation is again gauged by their income. Some hospitals that can look forward to reimbursing their maintenance funds from future earnings or from endowment income may accept patients for free beds beyond their immediate income.

We are admitting all emergency and acute cases from our out-patient department (which will have 100,000 visits this year) without regard to whether they can pay or not. How long we can sustain this burden is a question.

The welfare department has notified the hospitals that it will not support indigent sick in the hospitals, that it is limiting its care of the indigent sick to the Receiving Hospital, which is generally crowded.

The care of the sick unemployed does not differ from the general policy already stated.

*Thomas Howell, M.D., Superintendent,
New York Hospital, New York City*

It seems to me obvious that it is the duty of hospitals to care for the sick poor up to the limit of their physical and financial resources. As this limit is approached, demands should be made upon the municipalities for assistance. The city is supposed to care for its poor, especially when they are sick and unable to care for themselves.

It does seem that funds raised for the unemployed should be used in part for the care of the sick unemployed. They certainly are the most deserving. The only way to bring this about, as I view it, is through publicity and through demands on the distributing agencies.

How Hospital Libraries Are Growing in England

The principle of hospital libraries is steadily taking root in England, and is being followed by practical proof of the appreciation of a library system, according to an article in *The Hospital*.

Such proof has recently been given by the Royal Hospital, Richmond, which was one of the first to be organized by its local public library. It was opened in March, 1931.

The British public is being asked to give books and more books to supply hospital libraries.

"Books and libraries alone can ensure the lasting success of a national scheme for libraries for all hospitals," the article points out.

"Lying idle on countless bookshelves are books by the thousand. Unexplored, as yet, are the resources of most libraries. Unopened, as yet, are the doors of many hospitals to a cure which equals the care of the nurse and doctor."

The School Gives a Survey Lesson to the Hospital

A Paper From the American Hospital Association Meeting

By JOHN A. McNAMARA

Executive Editor, THE MODERN HOSPITAL

TOO often a hospital will launch a building program when no more additional beds are needed in that particular community and too often the aftermath of such a scheme means that the cost of good hospitalization is increased. When times like the past few years make their appearance, such hospitals are forced to close their doors because of the lack of patronage and because there are too many beds in the community for the proper and economic care of the sick and injured.

For many years various authorities in the hospital field have urged hospital trustees and superintendents to see that a thorough and honest survey was made of community needs before raising money for additional beds. Sentiment, however, often overrides common sense, and the net result has been mediocre hospital service to the sick, duplication of service, indifferent medical service and finally a loss of money to trustees and sometimes to those manufacturers and dealers who have sold to the hospitals. This creates an uneconomic condition that must be met by all of us, and it further means that whenever a hospital closes for lack of funds or lack of patients those hospitals that are well organized and well financed must pay, and pay dearly, for the other man's folly.

A Foundation for Future Plans

The remedy is so obvious that one is sometimes astonished that shrewd business men allow additions or new hospitals to spring up without first giving the matter the deepest of thought and without considering from all sides whether or not the additional beds are needed to supply the demands of the community. None of the trustees would launch a building program in his own industry until he knew to a nicety whether or not he was going to profit by it and whether or not his customers could support the added production.

The survey of the community and the community needs should be compulsory before a single

dollar is raised for building purposes. The survey should not be the hit-or-miss type and should not be made by anyone except those who are interested in the good of the hospital. Unfortunately, in the past surveys have been made that when they were completed were only selling talks or prospectuses for some consulting service. In other and perhaps plainer words, some surveys have been made by pseudo-consultants for the sole purpose of selling their services to the hospital when the building program was ready. This has been a grievous wrong and has broken down respect for honest consultant service and has generally held back hospitals from the proper place they deserve in any community.

Authentic Data Must Be Assembled

Since it is difficult to outline who should and who should not become a hospital consultant, nothing of this kind will be attempted here, but it is enough to point out that when a consultant uses data gleaned from an overenthusiastic chamber of commerce for about half of the purported survey, then proceeds to make two mistakes of fact and ends up with an urgent appeal that the addition be built immediately, it means that that particular consultant must have been extremely hungry for a job. Incidentally, there is a charge for all surveys, good and bad, and this one cost the hospital I have in mind about \$600.

In a questionnaire recently sent out by THE MODERN HOSPITAL, questions were asked regarding the division of ward beds, private rooms and semiprivate rooms, and upon whose judgment the division was made. It was impossible for the majority of those 700 hospitals answering to give any reason whatever for the division. This, of course, indicates that many communities were overburdened with private room accommodations and that when the recent depression was in full swing the revenue producing part of the institution did not function as was anticipated, while the free beds were in great demand. It must be

granted that we have gone through unusual times and are coming out in wonderful shape, but it is up to every hospital superintendent in the United States and Canada to get as many lessons from the recent hard times as possible because when the cycle comes around again we must be better prepared.

Since the hospital and the school are often linked together as the two educational forces of every community, I am going to take the liberty to review school surveys and how they are made. To begin with, the survey of any community's school system costs up to \$5,000, but when it is completed no doubt remains as to how many school seats will be needed, how many and what type of buildings, the kind of instruction that must be given to each pupil and what the community can logically expect to meet during the following ten years. In other words, when the school system has been surveyed, it stays surveyed for ten years.

The school survey is perhaps more complicated than is necessary for the hospital and health survey, but an outline shows that the educator goes into the past history of the community, the nature of its terrain, the industrial life of the community, the religious life, health conditions, the shifts of population from one center to another, the trend of movement of the Negro inhabitants, the foreign born and the American born, the development of suburbs, the political situation, the earning capacity of the citizens, outside influences that may endanger the wealth of the community, the type of instruction best needed for the children of the community based on the assumption that a percentage will enter the professions, a percentage will enter the trades and factories of the city and a percentage may become a burden to the community.

Working Out the Expansion Program

Conditions differ in different parts of a city and we find that the high school nearest the steel mills has to have larger and better equipped chemical laboratories because the boys have learned that the best paid employees of the steel mills are in the laboratory. We find that this changes as we near the automobile factory district where larger automobile repair shops are needed, and when we near the mail order houses we find that in bookkeeping and stenography vocational guidance is most needed.

These school surveys are made mostly by the personnel of the school superintendent's office under the direction of the consultant. In this way, true facts under competent guidance are obtained. It is also the most economical manner in which to make the survey. The consultant prepares or has

already prepared a list of about 1,500 questions that must be answered before he even comes near the city that is being surveyed. When all of these questions have been adequately answered he gets his assistants, who are often graduate students in schools of education, to analyze them and to tabulate them so that when he is ready for the actual survey he has at hand all essential information. In addition to this, he will then deal with a school superintendent who also knows just how the community stands and what will be needed. Together they work out the future program of school expansion.

Making the Hospital Survey

In hospital and community health surveys, it seems to me that much of this system could be adopted, with the result that all of the necessary building could be recommended, while all of the unnecessary building could be stopped before it is started. Let us apply this idea to hospitals.

First, suppose that the Middletown hospital feels that it should have additional facilities and the trustees of the institution know that they can raise the money for an extra building. If at this point a consultant was engaged to make a survey, it would mean that real facts would be arrived at and that no unnecessary money would be expended. Then let this consultant send to the hospital superintendent his list of questions, which must be answered in a thoroughly unbiased manner. What are the health conditions of the city? How many hospital beds are there already in the community? What is the community? How many physicians and how many surgeons are serving the community? What is the industrial condition of the community? How many factory workers are there who will want inexpensive accommodations? Is the industry of the community hazardous to the workers? What nationalities are represented? What has been the growth of population in the community? What are the trends of population? Is the community near another city and are many of the sick taken there for treatment? Are the highways good enough to expect the sick of the rural communities to come to the city? What is the birth rate and what is the death rate? Is there a community chest and is it fair to hospitals? There will be perhaps 200 other questions of this type.

Now suppose the superintendent, the medical staff, the department heads and the trustees have answered all of these questions over a period of a month or two months. The consultant is then ready to come to the community and spend perhaps a maximum of two days in making the finished survey. His fee for this work should be

considerably less than by the present method and his services will be worth many times the amount spent because he will have actual facts, not chamber of commerce fiction plus a greedy desire to get another commission for building the institution.

I believe that if some sort of arrangement could be worked out, it would mean that more hospitals would use ethical consultants and that the shysters in the profession would have to look for their prey elsewhere. It would mean that the hospital of the future would be built upon a definite knowledge of community conditions rather than upon the convincing sales talk of the unscrupulous.

There is another time when surveys should be made, and that is when things are going wrong at the hospital. One such survey was recently made of Kansas City, Mo., and Kansas City, Kan., by the American Public Health Association. The part pertaining to the hospitalization of the city was done by Dr. A. C. Bachmeyer, superintendent, Cincinnati General Hospital, Cincinnati, and Mary Hicks, associate in hospital administration study for the association, and could well be a model for this type of survey. Not only were the histories of the hospitals and their existing conditions accurately outlined, but each department of the public hospitals was taken up and discussed and definite recommendations were made. If these recommendations are followed, the two cities will be able to care for their ill more efficiently and economically than it is possible for them to do now. Nothing of an unnecessary nature was recommended. Only those expenditures were suggested that would ensure the elimination of overcrowding, better attention to all cases and better institutions generally.

How Self-Appraisal May Be Facilitated

There is no reason why a committee of the American Hospital Association composed of hospital administrators and those consultants who either are or have been successful hospital directors should not get together and outline a standard questionnaire that could be answered by the sponsors of the hospital and then submitted for analysis to a consultant chosen by the hospital. This would mean that every hospital in the country would have at its disposal means for a self-examination and a self-appraisal that could be used as often as necessary. It would mean that faults could be discovered and corrected in time in much the same way that we urge periodic health examinations for patients. It would mean that if we found conditions rapidly changing in a community we could change with them or else change our location—witness the hospital that

started in a quiet residential section that suddenly finds itself the center of a dirty and noisy factory district, or the hospital that suddenly finds itself included in an undesirable community.

The seriousness of this matter of surveys was recognized at the last meeting of the Ohio Hospital Association when a resolution was passed requesting the members to consult the officers of the association before building so that a survey could be made to determine the type and size of building needed. The lack of adequate community surveys was felt when several hospitals acknowledged defeat during the past two years and went into the hands of the receivers.

We all hope that the day will come when hospitals are enlarged, when the work done by hospitals will make them the health centers of every community and when hospitals will hold unquestioned places of authority in every city. We look forward to the time when fire traps and insanitary buildings will no longer be used for housing patients of any kind, when each hospital will be a model of perfection and when there will be a sufficient number of beds of every price for all of the sick of the community. To bring about this Utopia, however, we must proceed logically and thoroughly and we must be guided by needs rather than desires.

An Annual Report That Makes Charts Interesting

An annual report that makes a judicious use of color in the presentation of charts and maps that describe more graphically than words could the work of the hospital, is that issued by the Cooper Hospital, Camden, N. J.

The first illustration is a map, in colors, which shows the territory served by Cooper Hospital in its ward work. The second illustration is a double page spread of pictures of the hospital and the nurses' home. The pictures are not in colors, but they are outlined with a band of silver—an effective touch. The third is a comparison of the hospital's growth with that of the community, by means of yellow and blue and coral "chimneys" on a background of white. The fourth—a series of columns in black and white—shows the growth over a period of ten years of the accident ward and out-patient department. The fifth and last is called the Cooper Hospital thermometer, in which each year is represented by a thermometer in which the rising silver "mercury" reveals the number of bed patients treated since 1920.

The rest of the report follows more or less the regulation style.

Pictorial Publicity—One Way to Win Good Will

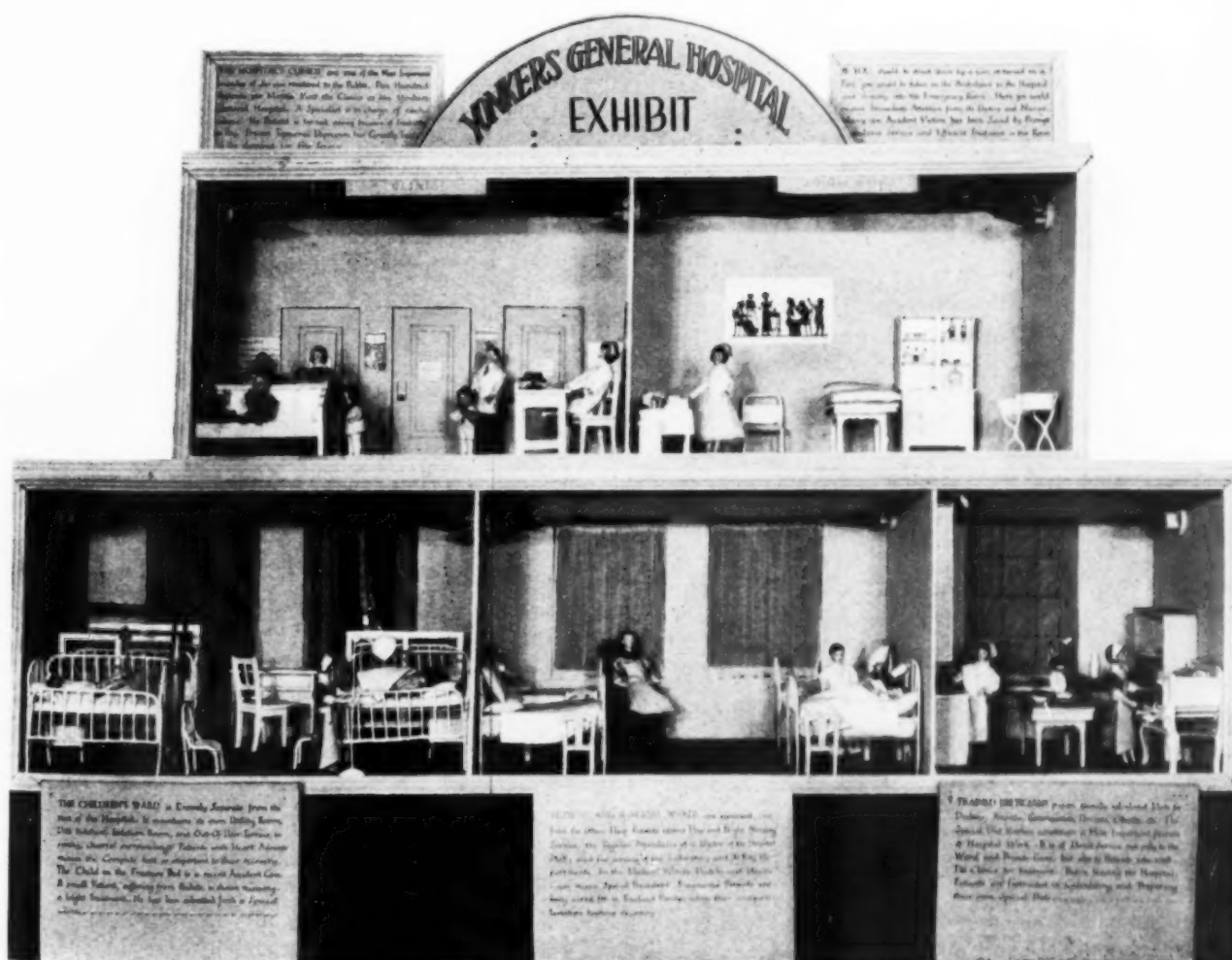
By MARGARET GEORGE
Yonkers General Hospital, Yonkers, N. Y.

THE problem of arousing public interest in institutions is one that deserves deep consideration. Not only does it require a complete understanding of the causes of existing indifference but also a continuous effort in the matter of intelligent publicity.

To a person who is familiar with the administration of a hospital, there is probably no other organization that possesses such a purely human, even dramatic appeal, and it is difficult for such a

person to comprehend an indifferent public. But, to be fair to the public and its apparent indifference, the average layman rarely has an opportunity to see the hospital in action. If he visits it at all, it is during regular visiting hours when things are quiet. Generally speaking, his conception of it is simply that of a large building somewhere in his community with which he connects exaggerated mental pictures of pain and suffering.

From time to time, he collects snatches of un-



A display of model rooms, depicting a minute cross section of hospital service in full swing and duplicating corresponding rooms in the hospital, cannot fail to attract attention and create public confidence in the hospital.

savory gossip concerning the happenings in the hospital (probably no institutions or persons are the subjects of more purely malicious gossip than are hospitals and doctors) and only upon the rarest occasion does he see or hear any of the good that comes out of it. If it needs money, he "hears" that it should be run on a business basis like a hotel; and if it does not need money he "hears" that by ably supporting itself it is overcharging and thereby robbing the public.

Educating the Layman

In view of such conditions, and they do exist in most communities, it is clearly the duty of the hospital to educate the average layman to see the vital human appeal of the hospital and, through its comprehension, to understand the hospital's need. The first logical step in this education is to destroy a few of his vague ideas concerning the hospital and to establish, in their stead, clear, well defined mental pictures of the real expanse of its administration.

Such a step was taken by the Yonkers General Hospital, Yonkers, N. Y., when it sponsored its first free exhibit with the single purpose of arousing public interest in hospital activities. For per-

fectly apparent reasons it was impossible to conduct a large number of citizens through every department of the hospital, but it seemed fairly probable that a well planned pictorial and model exhibit set up in a main thoroughfare of the central part of town, close to its moving picture houses, chain stores and apartment districts, would at some time during its existence, draw a great part of the population to its doors.

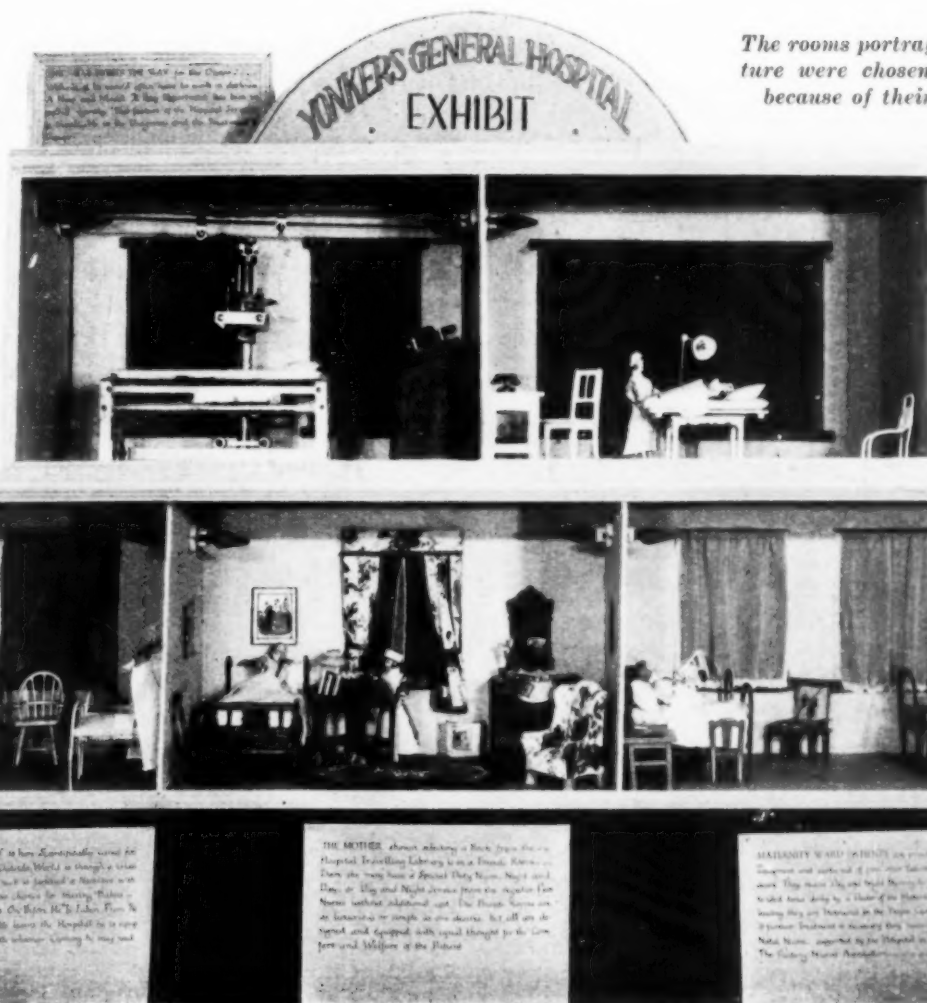
A vacant store upon the main street of the busiest section of town was gladly loaned by the owners for the exhibit. The front portion of the store was well lighted by large spacious windows with their greatest width parallel to the sidewalk, and the rear portion, when curtained off by heavy velours draperies, adapted itself perfectly as a small movie auditorium and lecture room.

Planning the Window Display

Of course, the window show was of first importance for it was that which formed the primary factor in attracting the passers-by. For this, model rooms were used. In each window there were five, arranged two above three, in stories, forming a minute cross section of hospital service in full swing. The exteriors of the models were attrac-



This attractively furnished semiprivate room, for which only a moderate price is charged, attracted the favorable attention of those visiting the hospital.



The rooms portrayed here in miniature were chosen for the display because of their public appeal.

tively landscaped. The approach to one side was formed by a gravel driveway where an ambulance was drawn up and where an intern and driver were in the act of removing a patient to the accident room. Not only were the rooms built and furnished in an exact duplication of corresponding rooms at the Yonkers General Hospital, but they were peopled by tiny dolls which depicted doctors, interns, nurses, dietitians and technicians performing various duties and patients receiving care.

Every Room Complete in Detail

Part of the rooms portrayed were chosen because of their public appeal while the remainder depicted vital but generally unthought of units of hospital work. Thus, one section was comprised of an emergency room, a clinic, a children's ward, a men's ward and a diet kitchen. Another section portrayed a maternity unit consisting of a four-bed ward, a private room and a nursery in addition to an x-ray room and a physiotherapy room. The variety of the rooms attracted and held the public interest, and the many pairs of eyes that sought out their details, in their minute study of what seemed a fascinating toy, absorbed much

of the background and scope of hospital work.

Each room was complete in detail and every detail worked. The x-ray apparatus, built by a doctor who specializes in that line of work, was adjustable and was connected to a tiny rheostat with switches charging real electric current to the x-ray lamp. The gadgets of the fracture bed in the children's ward were exact, and a genuine light beamed forth from the ultraviolet ray lamp with which a student nurse was in the act of giving a small patient a treatment. In some cases, hospital service which extended beyond the department modeled was suggested. A book wagon, drawn up to a patient's bedside, explained the free library service, and signs on the doors which led from the clinic reception room designated the specialized clinics, in addition to the clinic for children which was portrayed in the model.

Printed cards which described the function of each room further enabled the observer to understand the extent of the service of each department. With the exception of the x-ray room, the models were made by members of the junior committee of the institution, thus relieving the hospital of any expense whatsoever for their construction.

So much for the window show, our means of gaining attention. The next problem was how to entice the public inside. At first the people seemed wary and suspicious lest an appeal for funds be awaiting them, but signs announcing free movies each evening and daily free health lectures and articles and editorials by the leading newspapers soon allayed their mistrust, and gradually our exhibit became a success.

The walls of the front portion of the inside room were covered by enlarged photographs of the departments of the hospital not appearing in the model; with health charts, weight charts and diet charts; with yellow and black graphs showing thirty years of the hospital's expansion in annual census, clinic service and maternity service. The ratio of the nationalities of the patients was shown by a large flat map of the world, from which protruded a miniature in relief of the Yonkers General Hospital with threads extending from the hospital to the different countries represented. These countries were marked by brightly colored flags varying in size according to the ratio of patients represented.

How the Leading Doctors Cooperated

The system of marking babies with a name necklace before they are taken from the delivery room also was depicted clearly by means of a model and an accompanying card of explanation. A worker, constantly on duty and assisted by a uniformed nurse whenever possible, answered questions and distributed literature which was printed in five languages and which included the schedule of the free clinics.

A number of the leading doctors of the city cooperated by giving afternoon lectures, covering such subjects as pediatrics, maternity, cancer, hygiene, medicine and orthopedics, these being announced by the local papers on the previous evenings and reviewed on the following days. With the growing attendance of the lectures, more and more intelligent questions were asked of the workers. It was astounding to note the numbers of persons who had misunderstood the hospital's clinic service, and gratifying to see them realize the importance of its service to them.

Last but by no means of least importance was the movie that was shown every afternoon and evening. The pictures were taken at the hospital during actual working hours and portrayed an average day from the time the nurses reported for duty in the morning until they were relieved in the evening. Pictures of every department were included with a maximum of action and human interest, but with a minimum of sensation or of anything bordering on the tabloid.

An accident case was traced, showing the importance of efficient ambulance service, the necessity of an emergency room and the coordination and cooperation of the x-ray and operating rooms for the prompt hospitalization of such cases. Medical, surgical and maternity services were portrayed in like manner and linked with the services of laboratories, special diet kitchens, x-rays, clinics and other departments. The constantly active kitchens, the engineering rooms and the housekeeping departments were all given their part in bringing to the public eye the importance of every department's functioning perfectly in order that the smallest detail in the care of each of the hospital's patients shall be performed speedily and efficiently.

It is difficult to measure the results of the exhibit in exact terms. To be sure the attendance at clinics thereafter showed an increase but, most interesting to note, was the fact that out of the hundreds of persons who came, the great majority lingered to ask questions and to take away literature. These acts were sufficient proof of the gradual growth of understanding and intelligent interest which developed from what was at first only curiosity.

If, from the entire population of the town, even a small percentage of persons have become really hospital minded, then our efforts to clarify in the public mind the intricacies of the many and diversified departments, all necessary to the proper functioning of an up-to-date institution, have achieved definite results.

A Book Trolley That Is Used in English Hospitals

A specially designed book trolley for use in hospitals where a book service for patients has been established was recently exhibited at the annual conference of the library association at Cheltenham, England. It is described as follows in *The Hospital*:

"The trolley is a little over three feet high and even when fully loaded it is easily moved about and is not top-heavy. The top shelves are tilted so that the book titles are easily visible to patients when the trolley is at rest between the beds. Partitions have been introduced to prevent the books falling as the truck is wheeled about. The top shelf is slightly narrower than the second to allow the maximum amount of light to reach the book titles on that shelf.

"As the books are issued, the book cards are withdrawn and placed in the trays fixed on top of the trolley."

By What Criteria Shall the Trustee Judge His Hospital?

By S. S. GOLDWATER, M.D.

Hospital Consultant, New York City

WHEN Professor Caird was found on his deathbed reading St. Augustine's Confessions, he said that whatever philosophers might think of St. Augustine's answers to the questions he raised, they would have to admit he knew how to ask the right questions. The question we are about to discuss is: "By What Criteria Can the Trustees of a Hospital Judge the Efficiency of an Institution?" The answer is difficult, but it must at least be conceded that the question is one that should be asked.

There are several possible methods of testing hospital efficiency. The tests which the American College of Surgeons has so vigorously promoted are based upon principles of organization and of administration, and represent a method of examination that has proved useful within well defined limits. The use of comparative statistics is another method of testing hospital efficiency, and this, as we shall see, is not a method that can be safely entrusted to the unwary. A third method of approach might be described as the satisfied customer test; here reliance is placed on the patient's own opinion of the quality of his treatment. Now, although widespread dissatisfaction among the patients of a hospital is a certain indication that the hospital is not functioning as it should, many things may be wrong with a hospital about which its patients know little and care less. A patient may be well but extravagantly treated, which is all right for the patient, but bad for the hospital. One patient may be admitted in preference to another whose need is far more urgent—a situation, possibly tragic in its results, of which the favored patient might know nothing at all, and one in which he in any case would be a biased witness. Thus the

Hospital standardization is not a state or condition of being. Rather it is a process of growth and improvement, involving constant study and constantly renewed efforts to eliminate from hospital practice whatever is found to be inconsistent with the highest ideals of service for the sick.

judgment of patients cannot be regarded as final, and it becomes necessary to subject the work of the hospital to more searching, more impartial and more scientific methods of appraisal.

The statistical method may be employed for the examination of hospital work in a number of ways. The tables of comparative statistics that appear in so many hospital reports ordinarily measure the work of the hospital for the current year against that of

previous years. Through the preparation and publication of such reports the trustees and the public learn whether the volume of the hospital's work is increasing or diminishing, whether maintenance costs are advancing or receding, whether the deficit for the current year is greater or smaller than that of previous years. The shrewd and capable superintendent who wishes to make an impression on his board or on the local community often uses the statistical method for an entirely different purpose, namely, for the purpose of comparing the administration of his own hospital with that of others. Here crude statistics may be assumed to be a definite measure of results, when, as a matter of fact, they are no more than suggestive leads.

The terminology of hospital accounting, both clinical and administrative, will have to be molded into more definite shapes by uniform practice and common understanding before comparative hospital statistics can be accepted at their face value. I believe that the conclusions drawn from the comparison of hospital statistics are more frequently false than true, and we can easily see why this is so if we pause to examine certain terms that are commonly employed in an arbitrary manner.

1. Capital investment or "cost per bed."

To understand the meaning of this term it is

necessary to consider the influence of: (a) ratio of private rooms to ward beds; (b) inclusion or exclusion of the cost of the out-patient department; (c) the range of the hospital's laboratory facilities; (d) the presence or absence of dormitories for the help; (e) the extent of the development of a variety of auxiliary services, the need of which may be much greater in one hospital than in another; (f) the inclusion or exclusion of emergency bed space (solarium space, for example) in the calculation; (g) the effect of legal standards of ward space, or of the voluntary adoption of standards above the legal minimum; (h) the statistical use made of bassinets.

2. Per capita per diem.

This is a term which can be employed intelligently only if we make due allowance for: (a) differences in clinical classification; (b) differences in social classification; (c) the effect of extended teaching facilities and a program of scientific research; (d) quality of personnel; (e) grade of food service; (f) quality and intensity of nursing service; (g) degree of development of social service; (h) adequate development or relative neglect of follow-up work; (i) confused accounting, especially the failure properly to allocate cost items belonging to in-patient and out-patient services, or to private patient and ward patient services, respectively; (j) personal service for which no payment is made.

3. Deficit.

The following questions are pertinent: (a) Is allowance for depreciation made or omitted? (b) Is income from permanent funds taken into account before or after the deficit is calculated? (c) What sources of income (besides income from permanent funds) are disregarded in the calculation? (d) Is it the policy of the hospital to seek or to avoid a deficit? Is a "deficit," after all, any sort of guide to a hospital's efficiency, or is it merely a rough indication of the hospital's financial status and nothing more?

Questions That Challenge Thought

4. Ratio of bed occupancy to hospital capacity.

Here we must inquire into the influence: (a) of clinical and other classification, as influenced by the hospital plant, or by administrative policy, or both; (b) of variations in seasonal demand; (c) of unusual conditions of a temporary character, of which the business depression is a good example.

5. Ratio of hospital personnel to patients.

(a) Do staff figures include both paid and honorary officers? (b) How many listed workers are full-time, how many part-time, how many inactive? (c) Are the working hours of full-time employees the same as those of other hospitals in the locality?

(d) What are the relative numbers of professional and nonprofessional workers? (e) How many of those listed are engaged in activities of an auxiliary character, not associated with or not indispensable to the immediate care of hospital patients?

6. Percentage of recoveries.

It would be unjust to draw inferences from this figure without first inquiring how the hospital's statistics are affected by: (a) the special character of its clinical material; (b) its admission policy; (c) its policy or method of discharging patients.

7. Duration of treatment or average stay of patients.

What are, respectively, the influence of: (a) clinical classification, or the nature of the clinical material; (b) social service activities; (c) educational aims; (d) cooperation with the out-patient department; (e) cooperation with convalescent homes; (f) absorption of chronic cases by municipal or other institutions?

Statistics Not Always Dependable

One sees how difficult it is to read hospital statistics intelligently. At first glance the hospital whose per capita per diem figure is highest seems to be the most extravagant in its conduct when in fact this hospital may be performing a highly commendable service at a relatively low cost. The hospital with the highest death rate may be the statistical victim of its peculiar virtue; it may actually be the most competent, clinically, in its community, its high mortality rate reflecting the exceptionally critical or hazardous character of the clinical material its exceptional reputation attracts. The hospital that boasts of its short average period of treatment may be found on investigation to be leaving much of its work undone. Thus we see that hospital statistics may reveal or conceal essential facts, according to the manner of their use. For a true revelation of the processes of hospital administration we require a more precise descriptive terminology than is as yet available. In the development of better hospital accounting systems, local associations are in a position to make the greatest contribution, because methods of hospital operation vary so greatly in different parts of the country. It is fortunate for New York City that the task of systematizing local hospital statistics has been undertaken by the important and influential United Hospital Fund.

The second method of measuring a hospital's efficiency that we have to consider is that of observing the degree to which it conforms to basic principles of hospital administration. In this field national organizations can be most useful, and the

field has been most conspicuously cultivated by the American College of Surgeons, whose definition of minimum standards has been the means of converting many a hospital to better ways. A Japanese writer tells of a highly organized nursing service in Thibet, whose sole duty it is to prevent patients from going to sleep. In this country the American College of Surgeons has performed a similar function for the hospitals. Many a hospital has slumbered in peaceful inefficiency until gently prodded into a more wakeful state by a College questionnaire. But however effective the program of the College of Surgeons may be, it has its limitations, and a wide attack must be made on the whole hospital front to assure complete efficiency.

The reasonable minimum standards proposed by the College are now thoroughly familiar to hospital trustees and require no defense or elucidation at this time. Briefly, the College asks that the staff be organized; that it be composed of competent men; that rules and regulations be formulated for its guidance, providing, among other things, for regular staff meetings and the critical review of the end results of treatment; that adequate case records be kept; that diagnostic and therapeutic facilities (particularly those provided by the pathological laboratory, the x-ray department and the department of physiotherapy) be adequate and properly organized; that for scientific and humanitarian purposes autopsies be obtained in a given proportion of fatal cases and that the secret splitting of fees be abolished. The College is aware that the hospital has other professional needs and it therefore offers sound advice on the organization of the out-patient department, the nursing department and the department of dietetics.

Planning a Comprehensive Program

These basic arrangements and practices are of fundamental importance and indisputably sound, but satisfactory administrative standards cannot be achieved without dealing with additional questions that arise in respect to both the internal administration of the hospital and its relations to the community. Although complete discussion or even a complete enumeration of these questions cannot be given within the prescribed limits of this paper, the list of questions that follows will indicate how wide is the range of hospital activities that call for disciplined thought and action. Accepting and approving as of fundamental importance the minimum standards proposed by the American College of Surgeons, I submit the following questions as worthy of inclusion in a more comprehensive standardization program:

1. Do the facilities of the hospital correspond to community needs as revealed by an authoritative

survey, or does the hospital fail to satisfy the requirements of certain classes of patients that look to it for service? (Fine case records and careful diagnosis and therapy are all very well in their way, but afford little comfort to the patient whom the hospital excludes from its benefits. A large measure of freedom is given to hospitals under our laws, and the right to independent action has been known to result in the needless duplication of facilities and the neglect of important phases of hospital service.)

2. Does the hospital cooperate with other hospitals in a free interchange of records and experience?

3. Is the clinical organization well balanced, or is it distorted by personal or departmental interests?

4. Does the board, through appropriate committees, maintain sufficiently close contact with the hospital's diverse activities to enable it to legislate intelligently?

5. Is the superintendent of the hospital well trained, alert, impartial, public-spirited and of unquestionable integrity, and is the board unswerving in its support of such efforts as he may make to correct faults in the method or spirit of the hospital's work?

6. Do the trustees seek competent and impartial professional testimony concerning the qualifications of staff nominees?

7. Is a mechanism provided for the elimination, by the most painless method possible, of staff members who become unfit?

8. Is the emergency department equipped and organized to meet all emergencies promptly?

9. Is the admitting department safeguarded against undue influence?

10. Are penniless patients welcomed, and are they assured of all the essentials of treatment that can be bought by the wealthy from the hospital or from its staff?

11. Is daily contact maintained between the social service department and the various clinical divisions?

12. Are the hospital's resources sufficient to enable it to perform satisfactorily all of its recognized functions, including that of scientific research?

13. Do the hospital's interns, after graduation, usually attain such professional rank as to imply their intelligent selection and thorough training?

14. Is the nursing force adequate in number and quality, and is the teaching of student nurses properly organized?

15. Does the diploma of the school of nursing command respect?

16. Is the health of nurses and of other hospital

workers safeguarded by the application of the recognized principles of preventive medicine?

17. Are the highest sanitary standards maintained throughout the institution?

18. Are interdepartmental relations harmonious?

19. Are any of the hospital's employees paid less than a living wage, and if so, how does this condition affect the service of the hospital?

20. Is labor turnover excessive? If so, what is the remedy?

21. Are the expenditures of the hospital carefully budgeted?

22. Is a method provided for meeting urgent nonbudgetary needs?

23. Are the hospital's accounts independently audited by auditors of recognized ability?

24. Are unnecessary losses incurred through carelessness in the handling of patients' accounts?

25. Is the cost accounting system such as to prevent the unwitting use of charitable donations for the partial support of private patients or for the support of compensation cases for whose maintenance the law provides?

26. Are the purchasing methods of the hospital thoroughly businesslike?

27. Is there ample space for the storage of supplies that can be most advantageously bought in bulk?

28. Is the distribution of supplies subject to such control as to reveal irregularities or abnormalities at once?

29. Are heat, light and power bought or produced at the lowest possible cost?

30. Have fire hazards been eliminated?

31. Is food bought, stored, prepared and served under competent direction and at reasonable expense?

32. Are patients, staff and the help satisfied with the food service?

33. Is the stock of the pharmacy rigidly controlled with respect to quality and quantity?

34. Is a drug formulary in use which effectually minimizes the use of proprietary remedies that are costly?

35. Is the hospital burdened with buildings uneconomically planned and poorly finished and equipped?

36. Have plans been formulated for the logical development of the hospital?

37. Is the public kept informed concerning the hospital's work and needs?

To these questions, at least, the hospital must supply satisfactory answers before it can lay claim to a reasonable degree of efficiency. But no hospital, however well organized, can afford to rest on its laurels. It is a common mistake to regard

hospital standardization as a state or condition of being; it is rather a process of growth and improvement, involving constant study and constantly renewed efforts to eliminate from hospital practice whatever is found to be inconsistent with the highest ideals of service for the sick.

Hospital boards sometimes take it for granted that a satisfactory financial balance sheet is proof of good hospital management. What a mistake! A hospital superintendent, pointing to his success in wiping out a hospital's deficit, said that he had put the hospital on its feet. He had, indeed; but the feet were feet of clay, for the boasted triumph had been achieved by the simple expedient of discontinuing free service to the poor. Pityable indeed is the hospital that is controlled exclusively by business motives; yet we are bound as prudent men and women to question the efficiency of the hospital that is unbusinesslike in certain aspects of its administration.

Let us welcome into the family of hospital trustees the volunteer who approaches his task moved by pity and by reverence, but let us show him that ours is a cause in which head as well as heart is indispensable to effective service. And since the art of hospital administration is still in its infancy, let each trustee pray that he may never be tempted to regard his hospital the last word in hospital achievement. Again and again, as we strive toward the unattainable goal of a flawless hospital, we shall be reminded of the ancient adage that "before the gates of excellence the high gods have placed sweat."¹

Army School of Nursing to Be Discontinued

When the 1932 class is graduated from the Army School of Nursing, the school will be discontinued, on the recommendation of Surgeon General Patterson, approved by the Acting Secretary of War.

Economy was at the basis of the move. Another factor involved in the decision was that "the maintenance of a school for fundamental education which can be obtained in civil life is out of keeping with the present policy of the Army." It was also pointed out that no necessity exists for the Army School of Nursing as a source of supply for the Army Nurse Corps. There is no difficulty in keeping the corps filled with desirable nurses who are products of good civilian nurse training establishments.

¹Read at the Hospital Standardization Conference of the American College of Surgeons, New York City, October 12-15.

Providing Annual Medical Service in Private Group Clinics

By C. RUFUS ROREM, Ph.D.

The Julius Rosenwald Fund, Chicago

PHYSICIANS and hospital administrators in the Central West are familiar with private group clinics which, beginning with the Mayo Clinic, have been developing over this section of the country, particularly during the last fifteen years. In large cities like Minneapolis and Dallas and in towns of all sizes down to those of 5,000 population and less, groups of physicians have associated themselves for medical practice. They utilize common waiting rooms, equipment and personnel and conduct an organized clinic.

I had the opportunity of attending the sixth annual Conference of Clinic Managers, held in Toronto just before the meeting of the American Hospital Association. The trend of group practice is typified by this organization, and about fifty of the strongest private group clinics have been represented at each of the three annual meetings at which I have been present. The session this year included discussion of the subject of providing medical service for an agreed charge per year—medical care insurance, so-called—a topic of such growing interest that it seems to justify a report.

Basis for Clinic Service

The sessions of the clinic managers' conference were held at the Royal York Hotel, Toronto, many of the executives remaining for the meetings of the American Hospital Association and affiliated bodies. On the program of the clinic managers were included discussions of a number of administrative problems similar to those which face the out-patient departments of hospitals such as "Compensation of the Clinic Staff," "Insurance for Staff Members," "Correlation Between Clinics and Hospitals" and "Ways and Means of Financing Medical Accounts." Many of the clinics place their administrative problems in the hands of business managers who are laymen and the majority of representatives at the annual session were of this group, although the physicians and surgeons were also well represented.

The group clinics have, of course, been accustomed to provide medical care on the same basis as private physicians—fees for service as ren-

dered. Most of them continue to serve their patients exclusively in this way. But a new development is to provide service to a patient for an agreed sum per year. A substantial number of the private group clinics have consummated agreements for the medical care of certain groups of persons at annual rates, in addition to carrying on their medical practice on a fee basis for other patients. These agreements assure the individual that his expenses for the kinds of medical care that are provided will not exceed the amount stipulated in the agreement. They also assure the clinic physicians that the revenue for the medical care of a group of patients will not fall below a stated amount.

No two agreements are alike. Some are very inclusive as to the types of cases accepted. Others avowedly exclude some classes of persons and medical cases. In most instances, however, the agreements refer to the medical care of employed groups; consequently the prospective patients covered in the agreements tend to be of about the same economic and social status. A series of agreements or plans used by various clinics may be cited. These are arranged roughly in order of scope of service. The earlier examples represent offers of partial service and to relatively small groups. The later ones in the list provide comprehensive medical care, including hospitalization, to a large group of persons.

Planning for County Medical Aid

The recital of interesting cases opens with mention of two agreements which are in effect between small clinics and county authorities. The business manager of "A" Clinic in a city of 3,500 writes as follows:

"One of our doctors is just entering into a contract with the county officials for the care of county poor on a basis of 65 per cent of the charge as outlined in our workmen's compensation fee bill. The county nurse determines through investigation just what families are entitled to county medical aid."

A somewhat different arrangement is described

by the manager of the "B" Clinic, with six doctors in a city of 6,000. In a letter he described as follows the dilemma facing his group in the medical care of indigent residents:

"We have a contract with County for \$500 a year to take care of all 'paupers' located in District No. 1, consisting of four townships and the town of This contract provides that we shall supply all medicines (except vaccines, serums and neosarsphenamine for syphilis), do all x-ray work and surgery and attend all paupers in this district. Paupers are defined as persons who are dependent on the county for support.

"We find that \$500 does not cover the cost of the work we do each year, but the county supervisors call for bids each January and if we do not take the contract, some one else will. The people would still come to our clinic for treatment, and we would continue to do the work and would not get the money."

Cooperating With the Employer

The agreement of the "C" Clinic illustrates an arrangement between the clinic and an employer. The employees have no part in the annual agreement. It will be noted that the employees are entitled to free hospital care but that the costs of this service are not involved in the agreement with the clinic, which comprises ten doctors in a city of 310,000. The following quotation is from a letter from the clinic manager.

"With a railway company our agreement covers medical and surgical services including both major and minor surgery, but not the costs of hospitalization. We agree to make one residence call (or its equivalent) in each case. If the patient requires hospitalization he is ordered to the company hospital which is not in If unable to travel he is ordered to a designated local hospital.

"If the patient refuses to accept hospitalization and requires return visits by the doctor, we are allowed to charge the patient directly for the return residence calls (but we seldom collect on these charges). He may come to the office as often as necessary. This applies to sickness (except social diseases) and accidents, whether incurred on or off duty.

"We charge the railway company extra for x-ray work and laboratory work, generally giving them a reduced rate on this. Services in other special lines must receive special approval from the chief surgeon of the railway company.

"The remuneration to the clinic is \$250 monthly, plus whatever extra charges there are for x-ray and laboratory services. Each physician is given an annual pass for himself and his dependents on both local and foreign roads."

An arrangement followed by several clinics is typified by that of the "D" Clinic, a group of twenty doctors in a city of 300,000. In this case the individual patient is called upon to pay a portion of the costs of certain expensive illnesses. The agreement is with the local street railway company. One of the clinic physicians conducts an office hour each morning at the general headquarters where employees may consult him, with no charge. For this service the company pays the clinic a specified monthly amount.

The employees' association also administers a special fund for the care of hospitalized cases, to which the employees contribute through a monthly pay roll deduction. The association pays all physicians' and surgeons' fees and all hospital fees up to \$50. The remainder is paid by the employee. The clinic serves the members of the association and the members' families according to an agreed fee schedule. The association pays three-fourths of the amount of the clinic charges for services to the members' families. The family pays one-fourth. Hospitalization of family members is not covered by the contributions to the association.

It will be observed that this agreement recognizes three separate degrees of financial responsibility on the part of the person eligible to receive medical care. As an employee, he may receive office treatment at no cost to himself. As a contributor to the fund of the employees' association, he may receive medical and surgical treatment, a limited amount of hospital service, and a much reduced rate on practitioners' services to his family. If he is a patient requiring hospitalization costing more than a specified maximum, he must finance part of his own medical care.

A Successful Practice

The next plan, followed by the "E" Clinic in dealing with an employees' association, is somewhat different in that the clinic assumes no financial risk in the rendering of medical services. The clinic includes eight doctors in a city of 15,000 inhabitants. The welfare association of a local department store sends all employees who are members to the clinic for their medical services, and the association pays fees at the regular clinic rates from a fund created through monthly pay roll deductions and a general contribution by the store management. Each employee is entitled to a maximum allowance of \$75 for medical care in any one year. In commenting on the agreement, the manager of the clinic said:

"The store first asked us to take the contract on the basis of \$100 per month, but there were certain objections to our taking it on this basis. The average cost to the welfare association has run from

\$400 to \$600 annually, which is considerably less than the association anticipated. At the same time we have had our usual fee in every instance."

The "F" Clinic has an agreement with employees' associations to provide medical care (without hospitalization) at a maximum fee of \$1 per person per month, with the possibility that the cost to the association may be less than this amount. The clinic comprises twenty-two practitioners and is in a Southern city of 300,000 inhabitants.

Where Rates Are Low

The clinic gives medical service (excluding dentistry, maternity service, venereal disease care and treatment of drug addicts) at a rate not to exceed \$1 per employee per month. The work is done on a case basis according to an agreed fee schedule. If a patient has an appendix operation the clinic charges the association for this service. If he requires merely one office call during the year, the association must pay only for the call. If the total charges do not reach the maximum figure of \$1 per person per month the association must pay only the actual amount charged. The reason for making such an arrangement was to prevent the members from demanding excessive medical services and to provide the officers and directors of the association with an incentive to require only the necessary medical attention. The manager wrote as follows:

"We have not proceeded far enough to know whether we can profitably handle a large volume of business at these rates or not. We are, however, taking the attitude that this is about all that the associations can afford to pay, and we are striving to make our medical and surgical costs meet these figures. I believe when we own and operate our own hospital we shall be able materially to decrease our cost."

Clinic "G" is a group of ten doctors who own a hospital of seventy-five beds in a Middle Western city of 50,000. Seven years ago the same physicians were offering medical and hospital service at \$1.50 per month to several groups of employees. The chief of staff of the clinic wrote to me in August, 1931, as follows:

"We learned several things from this experiment. First, \$1.50 was somewhat low for the character and extent of service we rendered. Second, the bulk of the service tended to fall in the first year. Third, the beneficiaries, including employers, were delighted with the arrangement and protested when the plan was withdrawn. Fourth, the plan was generally disapproved of by the local profession as being unfair competition and was eventually prohibited by a special by-law adopted by

the county society. This action was our reason for discontinuing the economically and ethically sound practice."

This clinic has recently announced the reinstatement of the agreement for medical care and hospitalization (with certain limitations) at \$2 per person per month.

The "H" Clinic, on the Pacific coast, consisting of fourteen doctors, owns and operates a hospital of 200 beds. The clinic has agreements directly with employers of the city to provide certain medical and hospital services for employees, at an amount equal to \$1.50 per employee per month. The employers deduct the amounts from the monthly pay checks and make the consent of the employee to this procedure a condition of employment. The "H" Clinic has five arrangements with employers covering from 250 to 1,000 employees each. Hospitalization is limited to ninety days for any one case and to those patients who may be admitted to and treated in a general hospital. The medical services do not apply under the agreement to venereal diseases, maternity cases, chronic conditions, mental illness, or accidents resulting from illegal acts. All of the service covered by the agreement is separate from and in addition to the medical care given under the Workmen's Compensation Act.

The most extensive and inclusive annual service that I know of is provided by a group of twenty physicians on the Pacific coast, the "I" Clinic, to the members of several city and county employees' associations. The agreements provide complete medical care to employees and a certain amount of medical care to their families. More than 5,000 employees and families were covered by these agreements in 1931.

Two Dollars a Month Ensures Medical Care

Various employees' associations offer as one of the privileges of membership the right to be certified for medical care by the "I" Clinic. For this service the employer makes a monthly reduction of \$2 for each employee eligible for such medical care. The amounts deducted are paid to the employees' association, which in turn pays to the "I" Clinic an amount equal to \$2 per month per eligible member. Not all members of the various employees' associations subscribe for the medical service, but the percentages of subscribers in the associations appear to be growing. The first agreements with the "I" Clinic were established in 1929 and have been running successfully for two years.

As illustrative of the scope of the services covered by the various agreements, the following details of the agreement between the county employees' association and the "I" Clinic may be

cited: Members of the association who are certified to the clinic receive medical care without further payment. This includes all medical and surgical attention by doctors, including diagnosis, clinical and laboratory tests, x-ray examinations and treatments, surgical operations, professional consultations and home visits. All medicines and drugs are provided, except insulin. All dressings and splints are provided free, but a charge is made for orthopedic appliances, eyeglasses, dentistry, crutches, or sick room furniture. Patients may receive complete hospitalization, including special services, in the ward of a hospital selected by the clinic.

All classes of sickness and disease are treated, including mental cases, maternity cases, tuberculosis and venereal disease. Hospitalization is limited to three months in any one calendar year, and does not include treatment after a patient is committed to a state hospital for mental diseases or is transferred to a tuberculosis sanatorium. When the services of outside specialists are necessary, they are obtained at the expense of the clinic. Branch offices of the clinic are maintained, with twenty-four hour telephone service for emergency needs and prompt response to requests for house calls. A patient is expected to visit the offices for treatment, if his physical condition permits. A charge of not more than \$1 per mile is made for house calls for all distances in excess of five miles from a branch office of the clinic.

Patient's Family Also Benefits

Members of the patient's family who reside with him and are wholly dependent upon him for support are entitled to the same privileges as the subscriber himself, except that "the family dependents will pay the cost price for all medicines, drugs, dressings, splints, x-ray films, hospitalization, and 'outside' specialists' services." When a certified member of the association leaves the employ of the county, he may continue to subscribe for and receive the services from the clinic, upon the payment of \$24 per year directly to the clinic, in advance.

The "I" Clinic carries on a private practice, and doctors of the staff serve all patients at the same central and branch offices without distinction and usually without knowledge as to their subscriptions for annual medical and hospital services. The clinic does not own or operate a hospital but has staff privileges at several of the hospitals in the city.

The experiences reported at the conference of clinic managers in Toronto suggest certain general conclusions. The private group clinics represent a special type of organization of group

medical service from the standpoint of the physician. It is significant that they should also be experimenting with plans for group payment by patients for their medical care. Service based on annual agreements is usually referred to by the clinic physicians and managers by the somewhat invidious title of "contract" practice, a designation that emphasizes the certainty of revenue to the clinic. From the point of view of the patient the annual agreements are a type of medical care insurance through which the costs of medical care can be systematically provided for in his annual budget. The data that have just been cited and the interest shown by clinic practitioners and managers in this type of service point to the need for further experimentation along this line.

The Folly of Overitemizing the Patient's Bill

Fortunate is the institution that has a system of special charges that does not pave the way, when the bill is presented, for criticism and objection on the part of the patient. The whole system of special charges in hospitals has been the subject of much discussion in the past. Indeed, many institutions have cut to the minimum the number of special charges. Flat rates for laboratory, operating room, x-ray and other services when existing separately or when incorporated in the room rate are less often the cause of unfavorable comment by patients than when the expense of such services is itemized in too great detail on the patient's bill.

In many hospitals, a rather general rule exists which provides for special charges in the case of such unusual or expensive drugs as biologicals in ampules for intravenous use and for unusual or expensive foreign preparations, such as arsphenamin, insulin and agents of a similar character. The difficulty arises in drawing the line as to the drugs for which special charges shall be exacted. In some cases, no charge for less than fifty cents is made and in others a lump sum for special drugs is charged. In order to prevent criticism hospitals could easily include the cost of such drugs in the flat rate for private rooms. Tact and good judgment, however, should be used in the selection of a routine for the levying of special charges. The commoner drugs should be excluded from this class. Perhaps fifty cents a day, more or less, might be added to the room rate which would absorb the expense of drugs and dressings. At any rate, the institution must not lay itself open to criticism by appearing petty in its financial dealings with the patient.

A Department Store Hospital That Serves 15,000 Workers

By ISADORE ROSENFELD

New York City

FROM 13,000 to 15,000 persons are employed by R. H. Macy's department store, New York City. The average daily attendance of customers to the store is over 166,000. In addition thousands of vendors and others come in on various kinds of business. It is a city within a city, and so has many departments the functions of which parallel city departments.

Macy's has a well balanced program of welfare activities. There are various rest and recreation rooms, a library, a social service room, a cafeteria and, finally, the hospital, which is maintained jointly by the management and the employees.¹ The hospital takes care not only of the employees but likewise functions as an emergency station for customers and visitors. During the recent program of expansion the hospital was given a new location on the nineteenth floor and was considerably enlarged and modernized.

¹This hospital was designed by Mr. Rosenfeld under the direction of Frank H. Holden, manager, building expansion department. Dr. M. Lake, director of the hospital, acted as consultant. The work was done under the direction of Robert D. Kohn and Associated Architects.

This hospital is unlike any other hospital or clinic. Among the more important functions it performs, the following may be mentioned: (1) dental work; (2) pre-employment examination of candidates for employment who have satisfied other than health requirements; (3) periodic examination of employees, especially those who at the time of employment showed a suspicious symptom or a condition requiring correction; (4) the diagnosis and treatment of illness and accidents among employees; (5) the treatment of accident cases among customers; (6) visiting sick employees in their homes to see that they receive proper treatment; (7) temporary bed care of employees and customers who because of sudden illness or slight injury should be calmed by rest; (8) keeping records and charting statistics for the study of seasonal, occupational and other illnesses.

An examination of the plan will show the manner in which the various functions were met and interrelated. Two points may be gleaned from



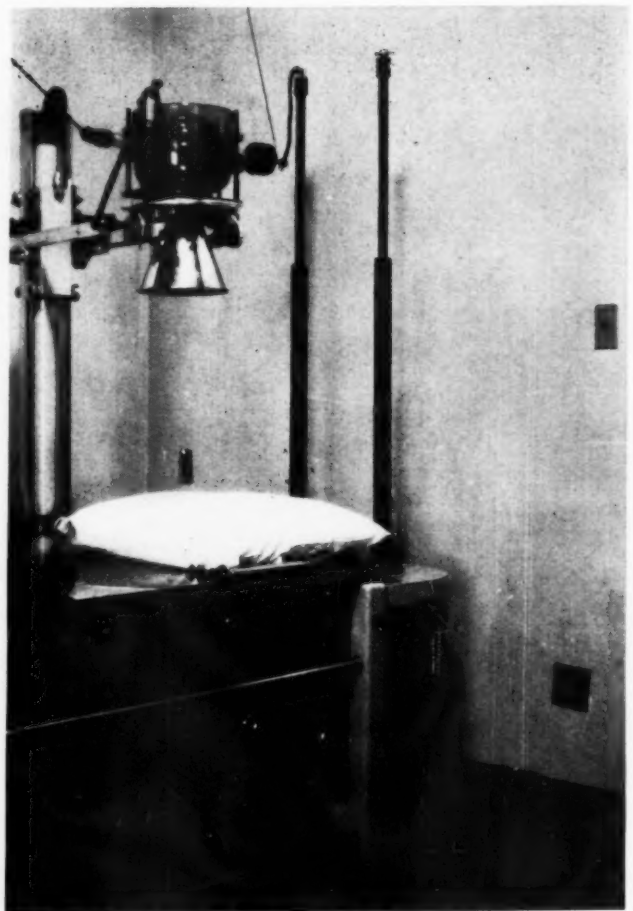
The center of activity in Macy's hospital is the lobby, where patients are directed to the various medical departments.

the plan as a whole: first, the simplicity of the lines of circulation from a single point, which is the lobby, and, second, the compactness of the plan. The shape and size of the rooms do not follow traditional lines. Rather each room is designed around the equipment and functions to be performed, without any waste of space.

The center of activity of course is the lobby. It is immediately controlled by the clerk's office, which is separated from the lobby by a rail. The lobby is in no way intended to function as the proverbial waiting room. The patient remains no longer in the lobby than may be necessary to get the record out of the files and to direct him to the proper room. Seating facilities are provided in each department.

The dental department is in the north corner. Here little waiting space is provided since all the work is done by appointment. The department consists of a series of treatment rooms, a small laboratory and sterilizing room, a recovery room and the necessary offices.

The pre-employment department is somewhat ingenious inasmuch as it is designed for a quick



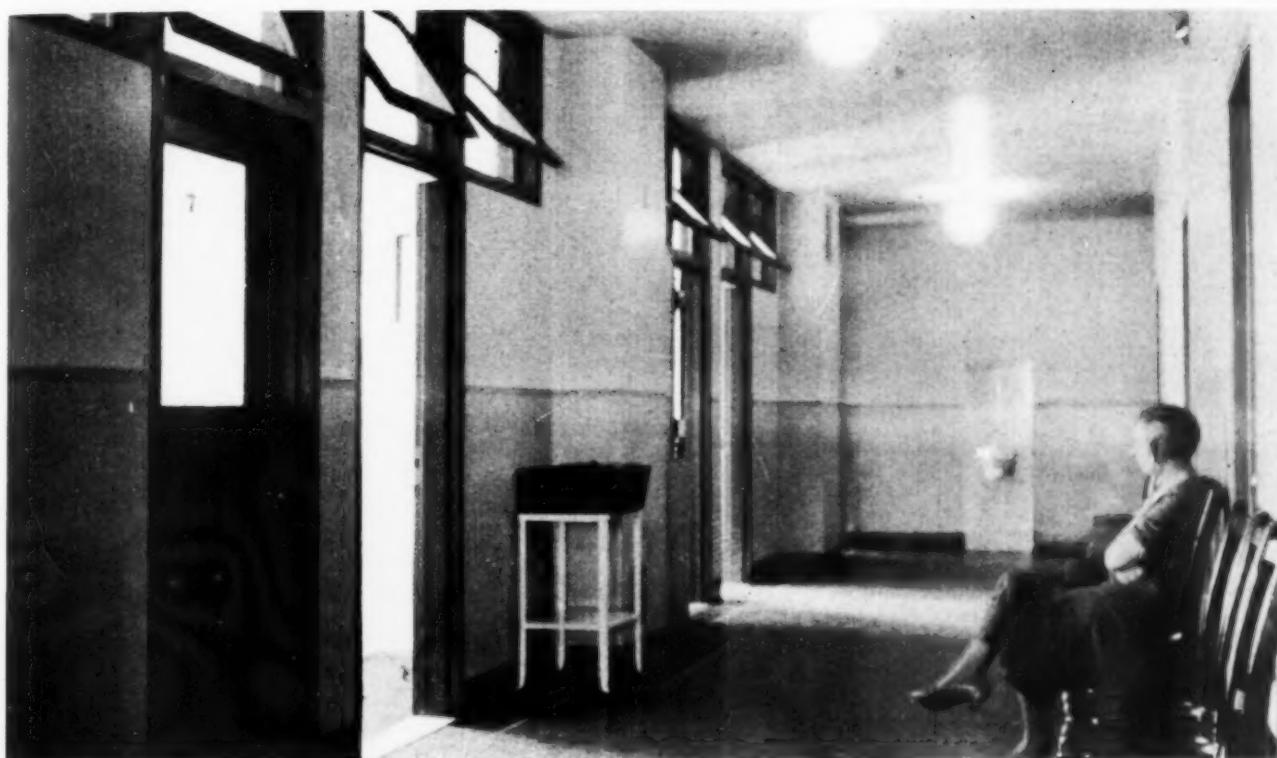
The x-ray suite is equipped for radiography, fluoroscopy and dental x-ray work.



Examination of the patients is facilitated by a light suspended on a reel over the examination table.

rotation of examinations. To begin with, all preliminary examinations are made by nurses in the two history rooms, one for men and one for women. From here the candidates for employment are directed to a dressing booth. Each examination room has two such booths and is controlled from within and from without by simple light signals actuated by the movements of the doors. Thus the patient and the nurse can readily see from the outside when a booth is unoccupied, and the doctor can see from the examination room when there is a patient in the booth. One patient is examined while the other is dressing or undressing. This arrangement saves the doctor a great deal of time inasmuch as he does not have to trouble about preliminaries or wait for patients to dress.

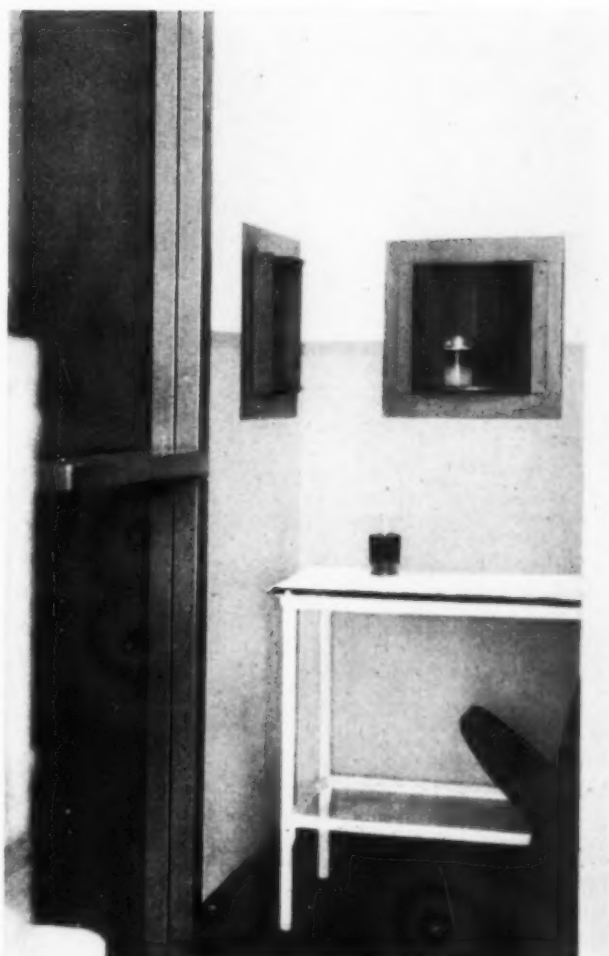
The laboratory is between the pre-employment and the medical departments. This arrangement facilitates the handling of work from both departments simultaneously. An interesting feature in connection with the pre-employment examinations is the manner in which the specimens are passed in to the laboratory. There are two small rooms adjoining the laboratory which because of their equipment may be called toilets but which are not toilets at all functionally. The men's room is



Space has been effectively utilized. Above is pictured a corridor of the medical department, where patients wait their turn for examination and treatment. The specially designed turnstiles for laboratory specimens, shown at the lower right, speed up the work of the laboratory technician.

equipped with a special sink which is like a slop sink but flushed like a closet. The women's room has a regular closet with an open front seat. The patient deposits the specimen in a bottle on which his name is written and places the bottle in a turnstile which is nothing more than a miniature revolving door. By a slight turn of the revolving stand the bottle appears in the laboratory and is there removed by the laboratory technician. Since there are four compartments to each revolving apparatus, it is not necessary for the technician to make constant trips from the table and back to the turnstile.

In the medical department, the facilities for diagnosis and treatment are quite complete. There is a series of the usual examination rooms. Each is equipped with an examination table, a sink, a cabinet for medicaments and drugs and a writing desk. These rooms are ranged in a series of "Director," "Nurse," with intercommunicating doors. This is another time saving device. As soon as the doctor finishes his examination he can communicate his orders to the nurse. The nurse then takes over the patient while the doctor proceeds with the next examination. In many other ways the work is facilitated by having the nurse in close proximity





The hospital in Macy's department store, New York City, takes care not only of the employees but also of customers and visitors. This plan shows the arrangement of the new quarters on the nineteenth floor of the store.

to the doctor. There is one feature in the doctors' rooms which is not universally found, and that is a special lamp suspended on a reel over each examination table. This provides a flexible lighting unit for examination purposes.

Special Rooms Are Well Equipped

In addition to the routine examination rooms, there are special rooms. There is the head room, for the treatment of eye, ear, nose and throat cases. This room is unusually well equipped. It has a dark room and a screened off space with chairs, which is used for patients requiring packing of the

the dark room. Access to this space is obtained through a high door opening on the utility room vestibule.

The utility room is equipped for sterilization work and bedside work. It is so placed as to be readily accessible from the bed wards as well as from the examination and treatment rooms of the hospital.

The physiotherapy room is a feature not always found in a welfare department of a corporation. It is an extremely important part of the plant since it is widely used in after care and in rehabilitation work. The features included are the major



Functionally the wards are only rest rooms, although in plan and equipment they resemble some of the better semiprivate wards. The women's ward is illustrated here.

ears or nose. This arrangement releases the treatment chair in the meantime for the treatment of other patients.

The chiropodist's room is peculiar to department store work. Since the clerks spend a great deal of the time on their feet it is important that they have healthy feet to stand on. Special provision, therefore, has been made for the care of the feet.

The x-ray suite is equipped with both radiography and fluoroscopy. Here is also equipment for dental x-ray, since it was deemed more important to have all x-ray work done by one technician rather than to save steps for the dental patient requiring x-ray.

There is one feature about this suite which is not obvious from the plan, and that is the absence of a generator and other electric apparatus, which generally clutter up an x-ray room. All such equipment is housed in a mezzanine above the maze to

facilities for hydrotherapy, massage and actinotherapy.

The wards are really only rest rooms as far as function is concerned. In plan and equipment, however, they compare with some of the best semiprivate wards. The beds are arranged in pairs by screens so that a patient may rest with a substantial measure of privacy.

The hospital has complete electrical equipment for all forms of apparatus. The signal system is also well developed. There is a nurse's call for every bed. The various dressing rooms in the pre-employment department and in the x-ray suite have apparatus for signaling the doctor. One interesting feature of the signal system is an alarm operating from the lobby and recording in the various corridors. This is employed for bringing the nearest nurse to the lobby when an accident case is brought in.

An Effective Credit and Collection System

By FRANK W. HOOVER

Superintendent, Elyria Memorial Hospital, Elyria, Ohio

THREE fundamentals to be kept in mind in establishing an effective credit and collection system are (1) an understanding of the financial situation of the patient, (2) financial arrangements made by persons of experience and judgment and (3) collection work carried on tactfully but persistently from the hospital office.

Legal action will be necessary in a small percentage of cases. If, however, the case is handled properly when the patient is admitted and during his hospital stay, no legal steps will be necessary.

How may we get a proper understanding of the financial situation of the patient? The head of the credit department should go over the admission cards each morning. In the case of well known families, well established financially, only routine presentations of statements will be necessary, but if the patient is unknown and his financial standing questionable, a thorough investigation should be made immediately.

Formulating a Practicable Plan

If the patient has recently become a resident of the city, the social service worker may be able to tell from the location of his home what his financial rating is. If he is apparently a charity case, steps frequently can be taken to have the Red Cross, the community chest, the municipal poor relief, or, if the patient comes from outside of city limits, the township trustees, pay for his hospitalization at a contract rate. Should there be an able-bodied wage earner in the family and the financial difficulties appear to be temporary, he should be called into the office and asked to sign a payment agreement.

Apparently, now, a plan that will take care of itself has been formulated. John Smith will pay \$5 on the tenth and twenty-fifth of each month which means that in eight months his bill of \$80 will have been paid in full. Practical experience has shown that John Smith will need a reminder the eighth and twenty-third of each month.

The superintendent will be tempted frequently to turn all of the hospital's troublesome accounts over to a collection agency. Hope, which springs

eternal in the human breast, would have him believe that his collection worries are now at an end—that when the hospital office has worked on the doubtful accounts for a few months they will be taken over and collected by an agency that promises results. For a short time the results will be satisfactory, but when the collection agency has sent out form letters and finally a threat to sue, the account begins to collect dust.

There has never been found any substitute for hard, consistent, persistent work for producing results in collection efforts. To my mind, the ideal collection system is one in which, for a period of at least eighteen months, the hospital mails out routine reminders over a period of from three to six months and then, depending on the individual case, individual letters once a month, interspersed with telephone calls, if the case is a local one, or frequent inquiries to the employer or the banker of the patient. Notices of replies that come in from time to time as well as a record of the payments on account should be made on the ledger sheets. If at the end of one year's work on the account, the patient is not paying regularly as large amounts as he is able to pay, a demand notice may bring him to his senses. Then, if all friendly efforts have failed at the end of fifteen or eighteen months of work, the case should be put into the hands of a collection attorney.

The weaknesses of the credit system in many hospitals are due largely to the failure of the superintendent to obtain information about the patient at the time of his admission, or, if he obtains the information, to follow it up.

The person in charge of the credit work of the hospital should not be a girl just out of high school or an inexperienced boy who is unable to weigh the statements made and to give them their proper valuation. He should be a person trained in credit work in some department store or in a corporation where things are not left to chance. A credit man should be a person of sympathy and pleasing personality, because a person with an offensive personality can do the hospital a tremendous amount of harm.

When Ten Million Dollars for Food Is Considered Well Spent

By GRACE M. BULMAN

Veterans' Administration, Washington, D. C.

A department devoted to the discussion of problems confronting both the dietitian and the administrator, conducted by Anna E. Boller, Central Free Dispensary at Rush Medical College, Chicago

WHAT do we eat? The popular question of army days is still an important one to patients and personnel in the hospitals under the Veterans' Administration. Every year approximately one-sixth of the entire hospital budget is spent for food. This food must measure up to high standards of quality and pass rigid inspection by field inspectors of the Bureau of Animal Industry, U. S. Department of Agriculture. Experience has proved that the purchase of high grade products decreases the food waste in the hospitals and brings gratifying results in the quality of the meals served.

During the fiscal year ending June 30, 1931, in the forty-eight Veterans' Administration hospitals operating throughout the year, 11,122,269 rations were served to patients and personnel at a total cost of \$10,399,094.99, or an individual cost per diem of \$0.93, including \$0.62 for raw food and \$0.31 for service. In six newly constructed hospitals operating less than a year, 326,268 additional rations were served, increasing the number during the entire year to 11,448,537.

Therapeutic Diets in Demand

Exclusive of regular and light diets, 846,656 of the total number of rations were therapeutic diets. These were distributed among the three types of service hospitals in the following amounts: 416,420 in general medical and surgical hospitals, 175,637 in neuropsychiatric hospitals and 254,599 in hospitals for the treatment of tuberculosis. Diet therapy is a definite part of the medical treatment of the disabled veterans and is carried out by graduate dietitians in accordance with ward surgeons' prescriptions. As far as possible patients on weighed diets are taught by the dietitian how to

compute and weigh their own diets, and those requiring prolonged dietetic treatment are sent to the dietitian for instruction before they are discharged from the hospital.

Year by year the number of infirm cases increases in the hospitals, and with this change comes a demand for more therapeutic diets. This is particularly true in neuropsychiatric hospitals, where chronic conditions, such as diabetes, nephritis, arthritis and heart and liver complications, are developing among the infirm patients and creating a need for a more extensive special diet program than has been necessary in the past.

Patients' Food Habits Are Studied

Menus for regular diet patients and personnel are prepared weekly by the chief dietitian, or by one of her assistants, and are approved by the medical officer in charge or the clinical director, before they are put into use, while special diet menus are planned daily to meet individual requirements in accordance with the ward surgeons' orders. The regular menu is planned to include all the dietary essentials in protein, carbohydrate and fat, correct amounts of fluid and residue, mineral salts and vitamins. It provides for approximately 2,500 calories daily with from 10 to 15 per cent of the total calories in protein. Whenever a high calorie diet is indicated, additional items are included to provide for 3,000 or more calories. The regular diet is used as a basis for the preparation of all other diets, as illustrated in the accompanying day's menu from one of the general medical and surgical hospitals.

Although a uniform quality of raw food is obtained for all hospitals through the central purchase of staple products and the local purchase of

perishable supplies that meet Veterans' Administration specifications, it has not proved advisable to attempt the standardization of items on the regular diet menus because of the variation in food habits in different localities. Thus, dishes such as codfish cakes on a New England hospital menu, spoon corn bread on a Southern one or chili con carne on one from the Southwest reflect the local influence regarding favorite dishes.

In addition to serving well balanced and varied menus, dietitians are expected to study the likes and dislikes of the patients and personnel so that universally popular dishes may appear on the menu with reasonable frequency and unpopular ones rarely, if at all. Emphasis is placed upon the use of fresh fruits and vegetables in season when price and quality are satisfactory, exceptions being

made only when items out of season are desired by critically ill patients.

A large central dining room for ambulant patients, and two or more for hospital personnel are usually maintained close to the main kitchen. The type of service varies with the condition of the patients and the number to be served. In the majority of the general medical and surgical hospitals and in those for the treatment of tuberculosis, waiter service is preferred because of the large number of patients who are not able to stand in line for their meals. The neuropsychiatric group favors a modified cafeteria plan whereby the patients select their hot food at the counter en route to their seats, and have beverages, second servings and desserts served to them by attendants or waiters. It has been found that efficient personnel

DAY'S MENU FROM A GENERAL					
	<i>Regular</i>	<i>Light</i>	<i>Fruit and Vegetable</i>	<i>Nephritic</i>	<i>Anemic</i>
<i>Breakfast</i>	1—Yellow plums	1—	1—	Applesauce	1—
	2—Shredded wheat	2—	2—	2—	2—
	3—Cream	3—	3—	3—	3—
	4—Bacon	Soft boiled egg	Soft boiled egg	Soft boiled egg	4—
	5—Toast—butter	5—	5—	5—	Soft boiled egg
	6—Coffee—milk	6—	6—	6—	5—
<i>Dinner</i>	1—Fried chicken	Cream of spinach soup	Cream of spinach soup	Cream of spinach soup	Liver soup
	2—Cream gravy	Roast chicken	Roast chicken	2—	Roast chicken
	3—Mashed potatoes	2—	2—	3—	2—
	4—Buttered peas	3—	3—	Peas and carrots	3—
	5—Bread—butter	4—	4—	Creamed celery	4—
	6—Maplenut ice cream	5—	5—	5—	5—
	7—Coffee	6—	6—	6—	6—
<i>Supper</i>		7—	7—	Cocoa	7—
	1—Bean soup—crackers	1—	1—	1—	Liver soup
	2—Eggs à la goldenrod	2—Cottage cheese	2—Cottage cheese	2—	Scalloped potatoes
	3—Hashed brown potatoes	Scalloped potatoes	Scalloped potatoes	Scalloped potatoes	Liver salad
	4—Pineapple cream cheese salad	4—	4—	4—No cream cheese	4—
	5—Bread—butter	5—	5—	Sliced tomatoes	5—
	6—Spice cookies	6—	6—	6—	6—
<i>Laxative</i>	7—Tea	7—	7—	7—	7—
		1—	Cream of spinach soup	1—	
		2—	Roast chicken	2—	
		3—	2—	4—	
	Soft boiled egg	3—	4—	Sliced tomatoes	
	Jelly	4—	Creamed celery	5—	
		5—	5—	6—	
		6—	6—	Fresh seedless grapes	
		7—	7—	Coffee	

carry out either form of service equally well and the overhead costs are approximately the same, but the cafeteria system lends itself more readily to the practice of providing a choice of items. In all hospitals, waiter service is provided in the staff dining rooms, and in most instances cafeteria service is available for the attendants and other unclassified personnel. Tables are maintained in the general patients' dining room, or in small rooms near by, for ambulant special diets. This practice reduces the number of special trays to be served on the wards and makes it possible to handle large numbers of therapeutic diets satisfactorily under the direct supervision of a dietitian. Whenever the seating capacity of the main dining room is limited, the meal hours for special diet patients are scheduled half an hour before or after regular meals.

With a few exceptions, the major preparation of food in each hospital is accomplished in one central kitchen from which direct service can be made to patients and personnel dining rooms and to central diet kitchens. From this kitchen electrically heated food conveyors carry food to other serving units in the hospital. Tray service is centralized as much as the physical arrangement of the buildings will permit. This results in less waste, requires fewer personnel and brings about a closer supervision of the tray service by a dietitian than would be possible if the setting up of trays were scattered among several diet kitchens. By means of heated tray conveyors food reaches the bed patients in an appetizing condition, even though it travels some distance.

When central diet kitchens are in operation, the

MEDICAL AND SURGICAL HOSPITAL

<i>Soft</i>	<i>Gastric No. 1</i>	<i>Gastric No. 2</i>	<i>Colitis No. 14</i>	<i>Salt Free</i>
1—Applesauce	Applesauce	Applesauce	Applesauce	Applesauce
Cream of wheat	Cream of wheat	Cream of wheat	Cream of wheat	Prunes
3—	3—	3—	3—	3—
Soft boiled egg	Soft boiled egg	Soft boiled egg	Soft boiled egg	Cream of wheat
5—	5—	5—	5—	Jelly
6—	Cocoa	Cocoa	6—	5—
	Hot milk	Hot milk		
Cream of spinach soup	Cream of spinach soup	Cream of spinach soup	Cream of spinach soup	Roast chicken
2—	2—	2—	2—	2—
3—	3—	3—	3—	3—
Puréed peas	Puréed peas	Puréed peas	Roast chicken	Peas and carrots
Toast—butter	Toast—butter	Toast—butter	Puréed peas	5—
Vanilla ice cream	Vanilla ice cream	Vanilla ice cream	Toast—butter	6—
		Minced chicken	Cocoa	
		Cocoa	Vanilla ice cream	
1—	1—	1—	1—	Scalloped potatoes
2—Cottage cheese	2—	2—	2—	2—
Scalloped potatoes	Scalloped potatoes	Scalloped potatoes	Scalloped potatoes	4—
Toast—butter	Toast—butter	Toast—butter	Tomato juice	5—
Cocoa	Cocoa	Cocoa	Tomato—butter	6—
Plain cookies	Plain cookies	Plain cookies	Cocoa	
	Fresh plums	1—	Hamburger	
	Cornflakes	3—	Stewed tomatoes	
	3—	4—	Lettuce	
<i>Diabetic</i>	Fried eggs	Muffin—bread	Applesauce	
	Bacon	7—	Muffin—bread	
	5—			
	Coffee	Strawberries	7—	

diet kitchens on individual wards are equipped only for serving between meal nourishments, such as fruit juices, gruels, malted milk and Sippy diets. These are prepared centrally and distributed to the wards once or twice daily in the amounts ordered by the ward surgeon or the charge nurse. When the isolation of wards or other factors make the central tray plan impracticable, separate ward diet kitchens are maintained and food service from them is usually conducted by the ward nurses co-operating closely with the dietetic department.

Utilizing the Food Waste

Factors bearing upon the elimination of waste in the hospital dietetic departments receive constant attention. Bones are sold and fats are used for cooking purposes or in making soap. In the larger hospitals carcass meats are purchased and the inferior cuts made into savory dishes. An excellent quality of corned beef is prepared from cuts unsatisfactory for steaks or roasts, for service to personnel and certain groups of patients, thus eliminating the possibility of stews appearing on the menu too frequently. Suitable equipment is furnished each hospital so that bread and butter cutting, meat slicing, coffee grinding, extracting fruit juices and preparing vegetables may be done centrally, thus effecting a saving in personnel and equipment, as well as in food supplies. The quantities of food prepared and the size of the servings are estimated closely. After each meal, left over food is returned from ward kitchens and serving rooms to the main kitchen, where the chief dietitian issues instructions regarding its proper disposition.

All food waste is separated into edible and inedible garbage, placed in cans labeled accordingly and sent to a central refrigerated section where it undergoes careful inspection by dietitians and others concerned. Edible waste includes all food that would be eaten normally, such as pieces of bread, meat or vegetables left on plates, while inedible waste includes such items as egg shells, coffee grounds, potato skins or orange peel. If farms are operated in connection with the hospitals, much of the food waste is fed to the hogs and poultry, while at other stations it is sold to local dealers.

The chief dietitian in each hospital is responsible to the medical officer in charge and to the clinical director for the proper functioning of the dietetic department, including all problems of administration and diet therapy. She is usually assisted by one experienced head dietitian and such additional dietitians in the entrance grade for government service as are necessary for the special diet needs of the hospital. Entrance re-

quirements for dietitians include graduation with a degree in foods and nutrition from a recognized college or university, and completion of a six months' student dietitian course in a Grade A hospital. Vacancies in the two higher grades are filled by promotion within the service, and in the lowest grade by the reinstatement of former Veterans' Hospital dietitians or by selection from the Civil Service registers of applicants.

The number of dietitians assigned to each hospital varies with the number and type of patients, the construction of the buildings and the number of food preparation and service units in operation. In the neuropsychiatric group, consisting of twenty hospitals with a bed capacity of 12,343 patients, there are forty-four dietitians; in the general medical and surgical group of twenty hospitals with a bed capacity of 8,241 patients, there are sixty-seven dietitians and in the fourteen hospitals for the treatment of tuberculosis with 5,723 beds there are fifty-four dietitians. In addition to a total of 165 dietitians, there are approximately 2,500 unclassified dietetic personnel in the Veterans' Administration hospitals. These include cooks, bakers, meat cutters, waiters, waitresses and kitchen helpers, who are selected locally, preference being given to ex-service applicants.

Twelve Years of Progress

This is the twelfth year in the development of the dietetic service for disabled veterans. It originated in the U. S. Public Health Service hospitals in 1919, and has been continued in U. S. Veterans' hospitals since the organization of the Veterans' Bureau in 1922. With the consolidation in July, 1931, of the National Homes, the Pension Bureau and the Veterans' Bureau into one organization known as the Veterans' Administration, the future dietetic care of the disabled veterans will include that rendered by the national homes as well as by the veterans' hospitals.

The degree to which satisfactory results have been obtained during the past twelve years in the veterans' hospital dietetic departments may be measured largely by the scarcity of food complaints, the contentment of both patients and personnel, the maintenance of reasonably low food and service costs, the efficient execution of special diet prescriptions, the close cooperation between all hospital departments and most important of all, the fine spirit of loyalty shown by dietitians and other personnel engaged in the preparation and service of food. Further developments in the dietetic service will be based upon the needs of the disabled veterans, and every effort will be made in the future, as has been done in the past, to meet these needs with promptness and efficiency.

How a Mental Hospital Disseminates Mental Hygiene Knowledge

By WILLIAM C. GARVIN, M.D.

Binghamton State Hospital, Binghamton, N. Y.

THE day has passed when mental hospitals can rest content solely with devoting their efforts to caring for the mentally sick within their walls. Psychiatry, especially since the World War, has widened its scope and concerns itself not only with intramural care and treatment of the mentally sick but also with such conditions as mental defects, epilepsy, behavior, child guidance, behavior disorders in children, truancy, early mental maladjustments in adults, so-called neurotic conditions, delinquency, crime and social unrest.

From experience gained in out-patient and mental hygiene clinics and especially in the work of the child guidance clinics carried on under the auspices of the Commonwealth Fund, it has been found that many of the pernicious trends of thought and behavior reactions present in adult life have their foundations in childhood and adolescence. Psychiatry, which began with the study of treatment of adult mental aberrations, is now laying emphasis on proper mental hygiene in childhood, a period when the young mind is plastic and moldable. This is the time when constructive mental attitudes and behavior should be developed in order that the individual may develop a well rounded out personality and thus be able to solve his own personal conflicts and adequately meet the problems with which he is daily confronted.

When Instruction Should Begin

Dr. William A. White, medical superintendent, St. Elizabeth's Hospital, Washington, D. C., has called childhood the golden period for mental hygiene. It is in this period, therefore, that preventive and corrective measures should be instituted in order to prevent mental breakdowns later in life. Unfortunately many adults have not had the advantage of proper early mental hygiene training and, in consequence, suffer from mental unhappiness and maladjustments in varying degrees. Many among this group never reach nervous or mental hospitals, but they can be materially helped by competent psychiatrists who are familiar with modern conceptions of the dynamics of mental life.

Preventive and educational work nowadays is an obligation that rests upon every well organized progressive mental hospital, not only with the view of diminishing the number of the mentally ill and of the increasing group of neurotic and maladjusted individuals but also of educating the public in matters of mental health. The necessities of the situation have practically compelled physicians in mental hospitals to assume the additional burden of educational work, as the number of psychiatrists in private practice is limited. The New York State Department of Mental Hygiene, which has control and supervision of the state's hospitals for mental disease, mental defects and epilepsy, has recognized this obligation. It has established a bureau of prevention in charge of Dr. Sanger Brown II, assistant commissioner of mental hygiene who is assisted by a number of psychiatrists, psychiatric social workers and psychologists.

Carrying Out the State Program

The state has a population of over twelve million and naturally any central bureau would find it impossible to minister to the needs of the entire state in the field of preventive mental medicine. Dr. Frederick W. Parsons, commissioner of mental hygiene, is of the opinion that the large cities, with their well organized hospitals and out-patient clinics, and with the assistance of local mental hygiene societies can take care of their own mental hygiene problems. The department has therefore limited its efforts to organizing a number of child guidance clinics throughout the rural districts where psychiatric service is not available.

Each mental hospital has its own district from which it receives patients, and each institution has been assigned the task of carrying on educational work in its district. All mental hospitals in New York State have established out-patient and mental hygiene clinics, which not only have supervision over patients on parole, but also render psychiatric service to the community in which they are located. To these clinics are referred cases from children's courts, schools, physicians, social workers, clergymen, charitable organizations and the like. The

staffs of such clinics consist of psychiatrists and psychiatric social workers. The latter interview patients, take a short psychiatric and social history prior to the examination by the psychiatrists and make psychometric tests. They also visit the homes of patients in order to make a study of the home situation, to see that recommended treatment is carried out and, when possible, to effect adjustments in their social and economical relationships. There is close cooperation among the clinics, the local social service agencies and the child guidance clinics established by the central bureau in Albany.

How the Binghamton Hospital Functions

The Binghamton State Hospital has a patient population of approximately three thousand, a staff of eighteen physicians, three psychiatric social workers and two volunteer social workers. The hospital district comprises eight counties along the eastern section of the New York-Pennsylvania border. The population of the district is approximately 500,000. The largest towns are Binghamton (76,000), near-by Johnson City (12,000) and Endicott (15,000). Other large centers are Elmira (48,000), Cortland (14,000) and Oneonta (12,000). Shoe making is the chief industry in the Binghamton district. Outside the larger centers mentioned the rest of the hospital district consists of small villages and farming communities. The population is largely native American stock, so we are not confronted with the language difficulties that exist in the metropolitan district.

The hospital at the present time operates five out-patient and mental hygiene clinics in the larger towns. Clinics are held at intervals according to the needs of the communities for which they function. Some are held once a week, others twice a month. A session for children is held in the morning and one for adults in the afternoon. The time, place and hours for clinics are announced in the local newspapers.

At first the clinics were deluged with an excess of patients too numerous for our clinic force to handle properly. The appointment system is now largely used. This works out more satisfactorily, as the social workers and physicians can give more time to each patient. These clinics, with their wealth of extramural material, both children and adults, have greatly enriched the psychiatric experience of the clinic physicians and have stimulated them to greater endeavor, both in intramural and extramural work. The educative value of this community work to our physicians is one of the striking features of the extrahospital activities. Moreover, it provides them concrete clinical material with which to illustrate their educational talks to various organizations in the district.

There has been a marked increase each year in the number of children and adults who come to the clinic for advice and treatment. One of the handicaps is a lack of social workers to carry on the necessary follow-up and environmental studies that aid the family in carrying out the treatment prescribed by the clinic physicians and to see that the patients report at the clinic for continued treatment.

Behavior disorders in children and mental maladjustments in adults are usually of slow growth and their improvement or cure takes the time, patience, persistence and cooperation of the patient, the family, the physician and the social worker. Should the legislature appropriate the necessary funds, it is intended to employ a full-time physician and social worker for this work. They will of course be assisted by the regular staff of physicians and social workers.

To develop further the educational and preventive work the State Charities Aid Association of New York City was called on three years ago to aid us in organizing a county mental hygiene society. This organization has for many years been interested in improving conditions with respect to the care and treatment of the mentally sick, and also in mental hygiene. They cordially responded to the request to send the secretary of their mental hygiene committee, Katherine Ecob, to Binghamton to have a conference with us, with the view of organizing such a society. A list was made of a number of prominent citizens in Binghamton and neighboring towns who might be interested in such a movement. Miss Ecob made personal calls upon many and obtained their promise to attend a meeting, which we planned to arrange later on.

Carrying Out the Program

Invitations were sent to the superintendents of schools in the county, to public-spirited citizens, judges of county and children's courts, health officers, physicians who might be interested in mental hygiene, social workers, visiting teachers, the schools, the Red Cross, the board of health, county nurses and clergymen. A date was set for a luncheon to which practically all who had been invited came. Miss Ecob outlined the scope of the proposed movement and officers were elected.

Publicity was given in the various county newspapers in regard to the society and its objects. A speakers' bureau was organized and a program of the various talks was circulated among parent-teacher associations, women's clubs, men's service clubs, teachers' associations, medical societies, child welfare and child study groups, nurses' associations, church organizations and the like. On

the speakers' program was printed an introduction, outlining the object and scope of the mental hygiene movement. The hospital physicians naturally constituted the bulk of the speakers, but care was taken to select those who could present their subject in interesting, nontechnical language. The development of normal mental attitudes in early life was continually stressed as was the best manner of handling mental conflicts. A number of laymen and laywomen who were especially interested in certain phases of mental hygiene were also added to the list of speakers.

Utilizing Lectures and Literature

The society arranged to meet several times a year and a definite program was outlined for the first year. It was decided to present the subject of mental hygiene through the medium of six lectures given by speakers prominent in the mental hygiene movement. The course was held at the Binghamton High School. A fee of \$5 was charged for the course. The speakers received an average of \$75 for each lecture. About \$1,200 was realized after all expenses were paid. This served as a working fund to pay for printing and for the traveling expenses of the speakers, in case the organizations before whom they delivered their talks were unable to do so. A survey of the county libraries was made and a list of desirable books and pamphlets on the various aspects of mental hygiene was provided them. They were requested to add this literature to their libraries in case they had not already done so. It was found that ten rural libraries did not have funds with which to make such additions. The society thereupon presented them with a number of desirable works with the understanding that each library would report to the society annually the number of books circulated and what special works seemed to be most in demand.

The second year's activity of the society was devoted to a survey of the schools in the county, with the view of ascertaining the need for ungraded classes. Influence was brought to bear on school boards to establish such classes when indicated. It is our intention to give a course of lectures on the child, the home and the school for the third year's work. The speaker will be a university physician who has devoted himself to the study of the normal child, behavior disorders in children and family situations influencing the mental health of the child. Because of the financial situation, however, it is probable that it will be necessary to postpone this plan until economic conditions improve. We may perhaps proceed with our plan and charge only a nominal fee for the course.

The society has also worked for psychiatric

service in the children's courts and has interested the superintendent of public schools in a psychiatric clinic for school service.

While the hospital has taken a prominent part in the education of the public in mental hygiene in our district, it was considered advisable at first to avoid stressing the subject of the psychosis or the graver mental abnormalities and to concentrate on the less malignant aspects of mental hygiene. This policy was adopted because the public is prone to consider insanity as embracing the entire field of mental disorders. A surprising number of requests, however, were received for talks on graver mental conditions and the work carried on by the hospital.

Some of our hospital physicians have given a series of lectures to the two normal schools in the district and to teachers, nurses and social service groups. A number of such courses have been arranged under the auspices of the state college and those who completed the course received two points credit for an A.B. or B.S. degree. The lecturer charged a fee for such courses. For individual talks, the speaker received his traveling expenses and if the organization had no funds, the mental hygiene society paid the bill.

How the Newspapers Cooperated

The newspapers in our district have cooperated with us in publishing announcements and printing abstracts of the lectures. The state department of mental hygiene has prepared a number of short pamphlets on the various aspects of mental health which we distribute at the lectures, to the patients who come to our clinics and also to the relatives and friends of patients who visit the hospital. In this manner a considerable amount of educational information regarding mental health is disseminated. The county medical society permitted one of our physicians to give a radio talk on "The Nervous Child," in its series of radio talks broadcast over the local station.

To encourage the physicians of the hospital to take a keener interest in psychiatry, especially in its broader ramifications, the Binghamton Psychiatric Society was organized, which included among its members a number of local physicians. These meetings are largely attended by outside physicians, nurses, social workers and some clergymen. Hospital physicians also give lectures on psychiatry and mental hygiene to a number of nurse training schools in the district. These are followed by clinics at the hospital. Clinics are also given for students of Elmira College and Syracuse University.

A feature of every extramural talk is the questions that are asked the speaker after the lecture.

It was found that the best way to make the members of the audience ask questions was to distribute slips of paper among them before the lecture and request them to write down questions that interested them. The questions asked referred to definite problems concerning the individual, his children, relatives or friends. In my opinion the question box was one of the most practical and constructive features of the meetings.

Members of the public are invited to visit the hospital at any time and are shown through certain parts of the institution under the guidance of physicians. A special feature is "Open House Day," held each year in the assembly hall. The occupational therapy department arranges a series of dances and calisthenics and has a display of the work done by the patients in the department. In addition, a leaflet containing interesting facts concerning the hospital is distributed.

Medical societies, women's clubs and nurses' associations are invited to hold their meetings at the hospital. We are willing if requested to prepare a special program for their meetings.

The work of the hospital and of the mental hygiene society has resulted in an increased dissemination of knowledge concerning the workings of the human mind both in health and in disease. It has also enriched the psychiatric experience of our hospital physicians, it has augmented the number of patients who resort to the out-patient and mental hygiene clinics for advice and treatment, and in many instances it has obviated the necessity for commitment to the hospital. Moreover, it has developed a greater appreciation on the part of the public of the work that is being done by the hospital. It is hoped in time to educate the public to the conception that mental disorders are not a disgrace, but should be viewed in the same light as physical disease.

The First Year of the Baker Memorial—A Review

That the Baker Memorial of the Massachusetts General Hospital has made available to its patients a type of service and a plan for the reduction of total costs that did not previously exist for them, is pointed out in a review of the first year's work of the hospital by C. Rufus Rorem published by the Julius Rosenwald Fund, Chicago. The report is called "The Middle Rate Plan for Hospital Patients."

The conclusions drawn by Mr. Rorem are that "the success of the Baker plan cannot be adjudged solely by the financial experience of the first year.

The first twelve months show that the total bill has been limited to a moderate amount compared with what is usual for similar service in the same community.

"The studies made of the 503 patients at the Baker Memorial indicate that the total cost to the average patient or his family was about \$160 altogether for hospital service, doctors' fees, and special nurses. Fully half of the illnesses, however, cost not over \$118. Such an expenditure is a large item in a family budget of \$2,500 a year, and it is a still greater percentage of the smaller budget of \$1,000 annually, which existed in some cases. The care of a hospitalized illness, therefore, must be regarded as a major item in the expenses of the fiscal period in which it occurs. Any device that can limit the necessary costs must be considered important.

"The ultimate soundness of the plan will be tested not only by the economies to the patient, but also by the effects upon the scientific standards and the earnings of doctors and nurses."

Because of the significance of the experiment of the Baker Memorial to provide hospital care for the patients of moderate means, the Julius Rosenwald Fund agreed to contribute toward the deficit that was expected at the hospital during the initial years, up to \$75,000 or 50 per cent of the deficit in any one year, and not more than a total of \$150,000 during the first three years.

Qualifications of the Hospital Administrator

What qualifications should the hospital administrator possess?

Dr. G. Harvey Agnew, department of hospital service, Canadian Medical Association, enumerates these qualifications in *Nosokomeion* as follows: a broad sympathetic viewpoint on life, for the hospital cannot be run entirely as an impersonal business; a shrewd business judgment, for the hospital cannot operate on sentiment alone; a keen psychological knowledge of people, in order to please the public and retain the loyalty of nurses and other personnel; a general knowledge of medical procedures and the professional viewpoint, in order to gain the cooperation and respect of the medical staff; executive ability, to maintain the confidence of the trustees or governors; a prophetic insight into the future, in order so to build and expand that future needs may be anticipated and incorporated into the hospital; a wide range of expert knowledge in accounting, purchasing, food preparation, heating and plumbing.

Selling Diet Therapy to Out-Patients Through a Special Clinic

By DOROTHY STEWART WALLER

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THE diet therapy clinic in the University Hospital, Ann Arbor, Mich., represents a joint undertaking by the departments of dietetics and internal medicine. It is designed to render service to two groups of patients. The first is the group that is being treated in any one of the various out-patient departments. There the patient's diagnosis is established and his treatment outlined and ordered. Prescribed diet therapy is therefore a part of the physician's discharge advice, and the patient's visit to the diet therapy clinic inevitably takes place near the end of his hospital stay. Since Ann Arbor is a comparatively small town, the majority of the two thousand new patients who come to the out-patient clinics each year are not local residents. Many of them come from distances of 100 to 400 miles. In many cases it is economically impossible for the patient to return for a check-up. When distance and lack of funds prevent their return, we must rely on correspondence.

This means that the dietitian must concentrate her effort and reduce her approach to the simplest possible terms. The aim of her endeavor—the institution of diet as a therapeutic measure—is the same as that of the dietitian who provides this service within the hospital walls. The equipment and methods of the two are of necessity different. The hospital dietitian achieves a therapeutic result through administration. The clinic dietitian achieves hers through salesmanship. Lacking the opportunity to teach through principles demonstrated in the daily service of trays, she must substitute vividness of presentation.

Over 3,000 Patients Visited Clinic Last Year

During the past year there have been 5,000 clinic visits, representing approximately 3,500 patients. The majority of these are referred to us by the medical out-patient department, although any out-patient department may recommend patients. Patients are referred for instruction in all varieties of therapeutic diets—reduction, high calorie and peptic ulcer; diets for atonic and spastic constipation, colitis, nephritis, anemia and allergy. Devel-

oping diet plans for this group with their widely divergent economic, racial, social and therapeutic needs offers a challenge and a stimulus of no mean order. As an observation and training field for dietitian interns and student nurses it is of incalculable value.

There is also a group of out-patient diabetics for whose treatment the clinic is responsible. These may be patients who are not ill enough to need hospitalization, or patients who have had their initial study and treatment in the hospital wards. The patients eat their weighed diets in a small dining room adjoining the diet kitchen which supplies metabolic diets for the medical floors. They are responsible for the collection of their own specimens which are brought to the medical out-patient laboratory for examination.

Medical Staff Members Serve Three Months

A member of the medical staff is assigned to the clinic for three months. He holds a morning clinic at which time laboratory reports and refers from consulting clinics are discussed and changes in diet are ordered. Classes are held daily except on Saturday and Sunday. Two classes are given each week by the doctor who discusses the nature of the disease, its treatment, complications and what to do about them and hygiene and its peculiar importance to the diabetic. Three classes are given each week by the dietitian, assisted by the dietitian intern and by the student nurses on duty in the clinic. These cover the essentials of good feeding, the application of these principles to the diabetic needs, the planning of emergency diets, the preparation of foods particularly useful in diabetic diets, as well as instruction in testing the urine for sugar and in the administration of insulin. Diabetic in-patients also attend these classes, and the clinic is responsible for their instruction. With a group of between twenty and forty patients, there is stimulating discussion. The patients also have the opportunity to learn, through seeing with their own eyes, the physical advantages of diet conscientiously followed and the consequences of advice disregarded or not sought in time.

Nutrition is playing each year a larger part in the medical treatment of disease as well as in public interest. If diet therapy is to be employed to advantage it must be more than the distribution of standardized printed lists. The patient is an individual and among his most personal characteristics are his habits of eating. Any prescribed diet should be built around his scheme of living. He is entitled to a diet which is (1) scientifically sound, whose fundamental principles he understands, (2) economically possible for him to include in his budget and (3) personally consistent with his personal, social and racial traditions. Provision for this will some day be accepted as part of adequate clinical facilities.

The "Back to Normal" Trend in Hospital Feeding

By KATE DAUM, Ph.D.

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AT NO time has there been such a keen quest for information in regard to food and its use in the body as is to be found now among hospital patients, nurses and medical staffs. This interest as well as an increased knowledge of nutrition has changed the emphasis in hospital feeding. Formerly the only patient who received much consideration was the wealthy patient or the one who was on a special diet. The general patient, the nurse, the intern and the employee were fed the cheapest food, prepared and served by the cheapest labor. Now the whole hospital population is fed on the best normal diet that can be afforded while at times even luxurious standards of food and service are maintained.

It might be questioned whether these luxurious and even extravagant hotel standards should be maintained in the hospital for the wealthy when it is considered how frequently wealthy persons become patients because of indiscretions in eating and drinking or because of the complexities that luxurious living has added to life. Simplicity and comfort with adequate and sympathetic nursing and medical care might be more to the point.

Observation of the feeding problem from the normal standpoint has changed our ideas as to the kinds of and the necessity for special diets. These are now considered as variations from the normal in as few particulars as possible with every normal requirement met adequately. This has so reduced the number of special diets that some hospitals have discontinued their special diet kitchens and are feeding all patients from a single kitchen. This method simplifies teaching and facilitates the

work of the nurse on private duty, since she has had practice in modifying the normal diet for the sick.

Another change is a recognition of the fact that the age old "payment in kind" is pauperizing to the worker and expensive in almost every way to the hospital. Where payment of an all money wage has been tried, better, more stable and more intelligent employees are available. Straight hours of labor and specialized and trained workers instead of Jacks-of-all-trades are other changes that are being made throughout the hospital.

The general interest in nutrition has changed the attitude of the hospital toward the dietitian. Formerly her status on the professional and administrative staffs was questioned. Now she is expected to be present when the treatment of the patient is being discussed or when administrative policies are being planned. As a matter of course this recognition of the dietitian's standing has brought to her new responsibilities with the result that she is now better trained than she formerly was. She plans her time to include professional contacts, makes her classwork for student nurses and dietitians educational and professional and realizes keenly that her department is of the utmost importance to the whole hospital.

A Camp That Is Run Especially for Diabetic Children

A camp for diabetic children is one of the projects of Grace Hospital, Detroit. It is the outgrowth of a clinic, and its purpose is to give the children care they could not get at home and to prevent, insofar as possible, the development of any abnormalities in the children that might be encouraged by the disease.

The American Red Cross camp on Carol Lake has been the scene of the experiment. Five years ago there were eight children at the camp. During the summer of 1930 there were fifty.

The camp is under the immediate direction of two interns, with four nurses, two recreation supervisors and one dietitian handling individual responsibilities.

Although every act is under supervision, the children are occupied in practically the same type of recreation that they would be in other groups. One of the clubs organized has been called the S. T. Y. D. Club—meaning "Stick to Your Diet"—to develop a spirit of independence in the group. One of its regulations is that the children must, as far as possible, earn the money to pay for the camp the following year. Such a camp costs about \$20 a week for each child.

A Small Hospital Superintendent Explains Her Record System

By ADELINE M. HUGHES, R.N.

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IT SEEMS to me that the difficulties of record keeping in a hospital of 100 beds or less begin with the lack of a well developed workable record system for a small hospital.

Records such as are kept by a large hospital, with interns and clerks, are too complicated and voluminous for a small hospital with no interns and few, if any, clerks, where most of the history must be written in long hand by the attending physician. There seems to be a need for blanks especially adapted to a small hospital whereon can be written in concise form with as little repetition as possible all the data necessary to conform to the requirements of the American College of Surgeons.

Under our present system, when a patient is admitted to Passavant Memorial Hospital, Jacksonville, Ill., five cards and seven sheets have been filled out. This does not include any extra sheets, such as operating room, eye, ear, nose and throat records, x-ray record and extra sheets for these special departments. The sheets all require the signature of the physician, and several of them call for a repetition of the working and final diagnosis. The doctor is a busy man and he does not think it necessary to give much of his valuable time to the writing of records, which he frequently thinks unnecessary and which apparently require so much repetition, when all he knows could be said and written in a few words. One must remember that many of our practitioners received their medical education before any systematic instruction in such matters was given, and they do not know how to write histories. Records become voluminous when the nurse's record is added. Frequently a record has to be divided and part taken to the record room. Although records occupy a lot of space, to destroy any of them is dangerous, as frequently they contain valuable information.

It seems, therefore, that records in a small hospital should be simplified. They should be more comprehensive and should contain little if any repetition.

The question is often raised, Why should hos-

pitals keep records? Why should any corporation keep records? Why does an insurance company keep records? Any business corporation would be discredited without records, and so should hospitals be. To be successful, a business must be conducted only in a businesslike, systematic way, and progressive modern hospitals should be conducted in the same manner, which will enable them to give better care to the patient, to reduce the number of hospital days and to lower their mortality rate.

Data That Should Be on the Record

The patient's record should contain the following:

1. The family history, to show how, if in any way, the patient's illness may be affected by heredity.
2. The personal history, which shows how the patient's environment may have a bearing on his illness.
3. The history of previous illness and previous operations (from childhood), to show how they may have a bearing on the present illness.
4. The complaints of the patient, which are recorded in order to show how they check with previous illness and with the present conditions.
5. The physical examination, which is to show any and all pathologic conditions not revealed by the complaints.
6. The present illness, which should show not only the present condition but its bearing on all the foregoing data.
7. The diagnosis, which should be in two forms—first, the preliminary tentative, or working, diagnosis, and, second, the final diagnosis, based on all the data gathered from the history and from chemical examinations and laboratory tests.
8. The laboratory tests, which give supplementary information as to the condition. Laboratory tests should confirm or disprove the clinical findings but should rarely be expected to result in a final diagnosis. They should be supplementary to the clinical findings.
9. The surgical operations, which should be

based on the physical findings, history and laboratory tests. All of these should show unmistakable indications for the operations. All this should be plainly brought out in the written history.

10. The progress of the patient, which should be recorded on the progress sheet, with a report of any complications, consultations or autopsy, and condition on discharge.

11. The cause of death, which must check with the death certificate or the coroner's findings and which should be attached to the hospital history. This is the reason why the history of a patient entering the hospital should be complete.

How the Physician Can Cooperate

Every effort should be made by the hospital to help the physician in charge of the case to learn the history and to record it. If there are not enough record clerks, one of the graduate nurses on duty in the hospital could receive instruction in the record department and could be assigned to this service. She could help the doctor with the examination, take his dictation and record his findings. I am offering this only as a suggestion and am not sure that it would be a satisfactory arrangement.

The physician should be educated to see the necessity for keeping records and should learn to appreciate their value, for after all they will benefit the patient and the doctor more than anyone else. Every doctor is afforded an opportunity to study and analyze his patient's records, which offer valuable information for research. The time will certainly come when a generous interchange of records will be made between hospitals as the patients go from place to place.

A patient entering a hospital approved by the American College of Surgeons believes that he is protected against fee splitting doctors; that in this hospital there will be x-ray and laboratory facilities, and all the scientific equipment and apparatus necessary to treat the disease with which he is afflicted; that a clean, well lighted operating room with expert graduate nurses in charge will be available if an operation is needed; that a complete record will be kept of all the findings and that they will be available if necessary for future reference.

Complete records are necessary for the business office, for compiling correct fundamental statistics, for future communication with the patient or his relatives or nearest friend, for providing such information as the courts may desire in lawsuits, to accumulate and preserve all recorded material for future reference and to make possible the compiling of instructive hospital statistics.

The record department should be well organ-

ized, well equipped and as near the doctors' entrance to the hospital as possible. There should be adequate space and equipment, such as desks, metal filing cabinets, typewriters, a telephone, supplies and cupboards for supplies necessary for the department.

The department should be satisfied with a record librarian, assistants and such clerks as are necessary. At Passavant Memorial Hospital we have found it satisfactory to gain the cooperation of the public library. One of their librarians spends four hours each morning in our record room and the rest of the day at the public library. We use the Dewey decimal classification, which all librarians in public libraries understand. This classification has been greatly expanded and adapted to hospital needs and has proved satisfactory. I am glad to recommend this system to other small hospitals which can hardly afford a full-time trained librarian but could provide for one half time.

We have made the service in the record room part of our school curriculum. The students serve one month in this department. In this way they learn how to keep a patient's record and realize a little better how valuable a document it is. A worker from the public library is able to instruct the students in record keeping, filing, classifying and summarizing. We make a summary card for each patient. These summary cards are the life of the system, as far as statistics and case study are concerned.

Financing the Department

A certain sum should be set aside each year by the trustees of the hospital for the maintenance of the record department. This is necessary. Only the superintendent of the hospital knows how rapidly the filing cabinets fill up and how much the supplies cost. It is also necessary for the librarian to attend hospital record and library conferences in order to get inspiration. It has been said that "it takes an interested record committee, an enthusiastic superintendent and a record librarian in love with her work to plan and carry on a record system." It is only by attending conferences and making contacts with her professional colleagues that the record librarian can maintain her love for the work and stand the constant rebuffs that she meets every day. The position is a trying one and needs a person who in addition to her knowledge of medical record keeping and filing possesses tact, personality, diplomacy and great patience.

It is difficult for a small hospital to secure and retain a record librarian with tact, training, and experience, one who understands medical terminology and is able to take staff dictation. Just as

soon as she becomes useful to the hospital, she is offered a larger salary elsewhere, and it is to her advantage to make a change. Then it is necessary for the small hospital to offer her a salary equivalent to the salary she might receive in a larger institution and every inducement should be offered to retain her services.

Easy Access to Records Is Essential

The records consist of only such facts as will be of benefit to the patient in the treatment of his case and to the profession in the treatment of similar cases in the future. They should be available at all times for scientific research, for developing useful and instructive hospital statistics and for professional medical statistics.

A report issued by the surgeon general following the World War was based upon data collected from the case records of the soldiers. It is hard to imagine the huge machinery that was in action and how perfectly every unit must have been working to make it possible to gather the material necessary for a complete case record of each soldier who was a patient at that time.

How can these records, which play such an important part in the standardization of hospitals of 100 beds or less, be assured?

Standard Nomenclature Needed

In the first place, records should be simplified, unnecessary repetition avoided and the history written in a concise, comprehensive form. A standard classification or nomenclature should be adopted, which is simple and comprehensive, yet meets the requirements of the smaller hospitals.

A questionnaire was recently sent to fifty hospitals in sixteen states, from Massachusetts to California and Minnesota to Louisiana, by a physician on the staff of our hospital, asking whether or not they would like to change their nomenclature. Eighty per cent replied. Twenty-seven per cent stated that they wanted a change, proving the need for a general, satisfactory, simple, concise, comprehensive, classification of diseases, one that can be generally used by all hospitals of 100 beds and less and that will make possible uniformity in hospital records.

The cooperation of nurses is necessary. The head nurse on the floor is responsible for the care of records and the recording of all acts of the nurses. This function is important and requires tact as this record may at times have to reveal delinquencies on the part of nurses and others. The head nurse will also have to call attention to various items that physicians and technicians have failed to record. Physicians are taking more interest in the records but the fact remains that

many of them do not know how to keep them. There must be whole-hearted cooperation of all members of the medical staff and an effort on the part of the standardization agencies to educate the staff members to use the records after they have been compiled, and so build up staff conferences by the use of records.

A member of our staff recently spent considerable time collecting data showing the number of deaths in the hospital during the past year, the cause of death, the treatment given, the laboratory findings, operations, if any, and other data, and from the information thus obtained charts, diagrams and graphs were made. This study was presented to the medical staff at the annual meeting and proved interesting. The same doctor is now at work on a five-year analysis of the cases of appendicitis that have passed through the hospital. When completed this study will prove interesting from a scientific point of view, and will also show how incomplete some of our records are.

There should be cooperation between the hospital management, the physicians, the nurses, the record librarian, the record clerks and the interns.

The record room should be well lighted and airy and should be easy of access, near the doctors' entrance and staff room. The personnel should include a trained record librarian; a typist who understands medical terminology and who has tact, personality and firmness, and who is persistent and optimistic, and assistants when necessary. The equipment should consist of the necessary fire-proofed filing cabinets, desks and supplies.¹

A Month's Service in Sixty New Jersey Hospitals

Sixty general hospitals in New Jersey had an average rate of occupancy of 64 per cent during October, according to a survey recently issued by the department of institutions and agencies. That is 4 per cent less than the average rate of occupancy for October, 1930.

Of the 18,062 patients who were hospitalized during the month, 37 per cent were admitted as private and semiprivate patients and 63 per cent as ward patients. Thirty-one per cent of the 233,916 patient days of service were given to private and semiprivate patients and 69 per cent to ward patients. The per capita daily cost was \$4.74 and compared with \$5.05 for the same month last year. The payments received from patients covered 57 per cent of the current operating expenditures.

¹Read at the meeting of the Illinois-Indiana-Wisconsin Hospital Associations, Chicago, May 13-15.

Practical Administrative Problems:

How Surgical Equipment Is Sterilized

THERE was begun in a recent issue of this magazine a series of articles dealing with the need for some standardization of surgical procedures and describing the great variety of steps commonly employed in the preparation of a patient for operation and in his subsequent surgical treatment. This group of studies is based upon information gained by means of a questionnaire sent to 125 leading hospitals.

It is the purpose of the present sketch to discuss the general subject of the sterilization of hospital materials—solutions and instruments—and to endeavor to crystallize the beliefs and practices of the hospitals in this regard.

Articles dealing generally with sterilization are prone to concern themselves with the selection and operation of the sterilizer itself. The manufacture of such utensils as are employed in the sterilization of basins, instruments, gauze and solutions has reached such a point of perfection that the hospital executive need no longer confine himself to the selection of the product of any one firm in order to be assured of securing reliable equipment. Not only have splendid advances been made in the past few years in perfecting such apparatus from the standpoint of safely sterilizing surgical materials, but safeguards against explosive hazards have also been developed to a high degree. It is rare indeed that a destructive accident resulting from the explosion of a sterilizing unit occurs. Nevertheless, the careful selection of a sterilizing outfit is an important matter.

Why Sterilization Should Be Perfected

And yet perhaps of greater concern to the hospital is the necessity for the perfection of the technique of sterilization. It is a fact worthy of remark that the handling of expensive and complicated equipment such as the sterilizing outfit of the hospital is too frequently left to pupil nurses who must be in a large measure unacquainted with the principles involved in the handling of steam under pressure or with the part the creation of a vacuum plays in the process of asepticizing hospital utensils and supplies.

The staff is prone to take little interest in the

matter of sterilization. And yet the physician should be vitally concerned in the exemplification of proper bacteriologic procedures necessary for the destruction of infective organisms. The possible contribution of the pathologist is all too frequently overlooked when it comes to routine checking upon the efficiency of institutional sterilizing methods.

Rules Seem to Be Lacking

It is a curious fact that the staff is rarely consulted as to the proper methods to be employed in the sterilization of instruments, either by heat or by chemicals. Nationally known medical and surgical associations have likewise failed to recommend proper standards. In few institutions is the mechanism of the sterilizer adequately taught, and it is rare indeed to observe in the training school equipment one or more new or even old sterilizers that are employed for demonstration purposes.

In the compilation of the answers to the questionnaire, many interesting facts were brought to light. For example, some institutions seem to believe that if 10 minutes of sterilization by heat or the use of a 5 per cent chemical solution is moderately safe, subjecting gauze or instruments to 60 minutes of sterilization or instruments to a 100 per cent chemical solution would be proportionately better. It will be seen at once that the increase of several hundred per cent in time or in the concentration of a chemical is not wholly a trivial matter. To expose instruments and supplies to an hour's superheated atmosphere or to a highly concentrated antiseptic cannot avoid, in some instances, producing deterioration in the articles. But to an even greater degree, the unnecessary expenditure of time which such prolonged procedures must entail is a preventable loss to the hospital.

In answer to the question as to the type of solution most frequently used in operating rooms, a diversity of statements were made. In some, a saline solution was employed. In others, sterile water only was used. In still others, either was employed. The terms isotonic, hypertonic and

hypotonic appear to be only interesting adjectives, difficult to pronounce but with no particular, definite application to operating room solutions. After all, it seems that there remains much of mysticism and theory concerning such practical steps as the destruction of germs. And in some instances institutions do not seem to be so far removed from the days when the air of the operating room was filled with evil smelling sprays employed to dispel viruses, miasmas or germs. Perhaps it makes little difference insofar as the patient is concerned whether salt solution or sterile water is employed in the operating room hand basins to saturate sponges at the operating table. Certainly it makes a great difference whether single distilled, double distilled or triple distilled water is employed for intravenous use.

The Overofficial Nurse

Here and there one observes new and novel ways that have been evolved by nurses, overendowed with initiative, to sterilize hospital materials. Usually such methods receive no approval from staff members, and in fact in some instances it seems that because of lack of interest or even of information, these persons are not always qualified to act as advisers. In one hospital, a new method of sterilizing gauze sponges and of facilitating their transportation was devised. This consisted of placing sponges in jars similar to fruit jars, autoclaving them for a definite period and then transporting the unopened jars to the various departments of the hospital for use. Of course, it need not be remarked that no sterilization is likely to have taken place under such conditions.

The efficiency of sterilizer control is another matter of great interest and importance to the patient. In 66 of the 104 hospitals answering this questionnaire, a well known patented control was used. This group consisted of 63.4 per cent of the whole. In 18 or 17.3 per cent other thermometric controls were employed. In 13 or 12.5 per cent, no thermometric control was used. In 42 or 40 per cent, both a patented control and other methods such as the use of gauges were employed. In 61 or 58.8 per cent, steam gauges were completely or largely relied upon, although in some of these institutions a patented control was employed as a check. In 23 or 22 per cent, steam gauges were not used. In 16 or 15 per cent, steam gauges were employed, but cultures were taken periodically from supposedly sterile materials.

An expert on hospital sterilization has recently remarked that to rely wholly upon steam gauges as indicators for safe sterilization is a mistake. Steam gauges do not actually tell anything concerning what has occurred within the sterilizer,

except that its contents have been subjected to pressure that might have been air but probably was steam. If it were air, sterilization may easily not have occurred. The patented control or one of the new lag thermometers is much more likely to guarantee the destruction of infective organisms than any other safeguard now in use.

The sterilization of water in the hospital is a matter upon which many institutions differ as to procedure. In 29 instances or 28 per cent of the group studied, water was sterilized by nurses on the wards or departments in which it was used. In 72 or 70 per cent of the group, this work was performed in the operating room.

It will be seen that there is a strong tendency toward centralization in the preparation of sterile water. Indeed, in some newer institutions complicated and rather expensive equipment has been provided whereby sterilization of water takes place on a floor far distant from the operating room. The water is stored there in tanks and is transported by pipes to the place where it is needed. It seems that the trend, therefore, in the preparation of sterile water is to place this task permanently under the supervision of a trained person. There is a difference of opinion as to the safety of the sterilization and storage of water at a point distant from the operating room and its transportation there by means of pipes. In some hospitals, the central dressing room idea has been developed so that here are prepared not only sterile dressings, but also sterile solutions of various types, which are transported in properly stoppered flasks to the places where they are used.

Sterilizing Gauze Dressings

The sterilization of gauze products is a matter of great importance. In practically 100 per cent of the hospitals interviewed, an autoclave was employed to perform this work. A greater variation, however, existed as to the time and the number of pounds of pressure employed. For example, in 18 hospitals or 17 per cent of the whole, 15 pounds pressure was employed; in 16 or 15 per cent, 18 pounds pressure was employed; in 51 or 49 per cent, 20 pounds pressure was employed; in 11 or 10 per cent, 25 pounds pressure was employed; in 1, 30 pounds pressure was employed, and in 6, various other pressures were used.

From the standpoint of the length of time of exposure, a still greater variation was found to exist. In 1 hospital, 10 minutes; in 2, 15 minutes; in 10, 20 minutes; in 37 or 35 per cent, 30 minutes; in 4, 40 minutes; in 37 or 35 per cent, 45 minutes; in 20 or 22 per cent, 60 minutes.

Surely, there must be some minimum point of safety, both from the standpoint of pressure and

of time of exposure, and it seems that a nationally known hospital, surgical, medical or bacteriologic association should develop standards covering this point. From the foregoing statement, however, it may be concluded that: (1) The autoclave is most often employed in sterilizing gauze products and, as will be seen later, it is sometimes used for instruments and gloves; (2) the majority of hospitals believe that the exposure of these articles to 20 pounds pressure for an average of 45 minutes represents the maximum of safety.

How Instrument Sterilization Varies

The sterilizing of instruments is another matter upon which many hospitals differ. Most hospitals believe that the boiling of surgical instruments is a proper and safe procedure. In certain of the hospitals interviewed boiling water was used as follows: In 9 or 8 per cent, instruments were boiled 15 minutes. In 21 or 20 per cent, instruments were boiled 20 minutes. In 64 or 61 per cent, instruments were boiled 25 minutes. In 8 or 7 per cent, instruments were boiled 30 minutes. In 1, instruments were boiled 40 minutes.

In some institutions, there was a variation of technique which depended on the type of surgery to be performed. In general surgery, in one case, boiling for 20 minutes was thought to be safe, but in preparation for orthopedic surgery, the instruments were boiled 30 minutes. When single instruments were required during an operation, but 3 minutes' boiling was felt to be satisfactory. One might be justified in asking whether an instrument boiled for 3 minutes could not do as much harm as an infected one boiled 30 minutes.

In another hospital, instruments were boiled 12 minutes following clean operations and from 20 to 30 minutes following operations on infected areas.

From the foregoing statements, it seems proper to conclude that most institutions boil their instruments for 20 minutes, although in 20 per cent of the cases boiling for 10 minutes was felt to be safe. If 10 minutes' boiling will sterilize instruments for a general surgical case, why is it necessary to boil bone instruments for 30 minutes?

As to the use of some chemical in the water in which instruments were sterilized, a considerable variation in practice was also observed. Seventy-six hospitals or 72 per cent did not add soda or any chemical to the water used for sterilization; 9 hospitals or 8 per cent employed 1 ounce of soda to each gallon of water; 3 hospitals stated that they employed 1 per cent sodium bicarbonate solution; 17 or 16 per cent employed the autoclave in the sterilization of surgical instruments; 6 exposed instruments to 25 pounds pressure for 10 minutes; 1 exposed instruments to 20 pounds pressure for

15 minutes; 6 exposed instruments to 17 pounds pressure for 20 minutes.

In some cases, it was stated that a mineral filtration apparatus was used to soften the water. In others, certain proprietary sterilizing tablets, two to the quart of water, were employed to prevent instruments from rusting (11 hospitals).

It seems, therefore, that it is not believed necessary to employ soda or other chemicals in the water in which instruments are boiled, and that it is advisable to use water that is not too heavily laden with alkaline bodies in instrument sterilizers.

In regard to the methods employed in the sterilization of special instruments, interesting information was secured. Scalpels, for example, were sterilized both by the use of heat and by chemicals. Thirteen institutions, or 12 per cent, sterilized scalpels in boiling oil at 300°. Others stated that they used boiling oil at 110° C. (265° F.) for 20 minutes. Others simply stated that oil was used at a temperature of 150°.

It seems, therefore, that the use of boiling oil for the purpose of preventing rusting is not altogether unpopular, but that comparatively few institutions (one-eighth of the whole number) were equipped to employ this method. Twenty-three hospitals or 22 per cent boiled scalpels in water for 20 minutes.

As to the chemicals employed, 2 hospitals used 20 per cent compound solution of cresol (time unstated); 1 used pure compound solution of cresol for 5 minutes; 2 used 5 per cent compound solution of cresol for 30 minutes; 3 used compound solution of cresol and alcohol for 12 hours.

If compound solution of cresol is a suitable antiseptic to employ, some decision should be reached as to the proper strength and the time of exposure.

Alcohol Concentrations That Are Used

Alcohol remains perhaps the most popular chemical employed in the sterilization of hospital instruments. There was a great variation of opinion, however, as to the optimum concentration to employ. For example, 11 hospitals used 70 per cent alcohol for 3 minutes; 5 used 100 per cent alcohol for 10 minutes; 1 used 60 per cent alcohol for 30 minutes, and 2 used 95 per cent alcohol for an unstated period.

It may be remarked here that it is the belief of many that 70 per cent alcohol is the most effective concentration to be employed in sterilizing instruments.

Phenol is apparently another popular drug for sterilizing instruments. Fifteen institutions reported using 95 per cent phenol and 70 per cent alcohol; 1 used 20 per cent phenol and 50 per cent alcohol; 1 used 95 per cent phenol and 50 per

cent alcohol; 8 used 95 per cent phenol and 95 per cent alcohol.

There were many variations reported in the methods of employing these two chemicals. One institution specifically stated it believed the use of 70 per cent alcohol for 5 minutes and pure phenol for 3 minutes was proper, followed by sterile water; 12 reported merely that phenol and 90 per cent alcohol were employed in sterilizing scalpels.

It may be concluded, therefore, that the use of oil in sterilizing scalpels is infrequently observed; that compound solution of cresol of varying concentrations is sometimes used, but that the most popular method is the boiling of scalpels for 20 minutes or the use of alcohol and phenol in 70 per cent and 95 per cent concentrations, respectively. Five hospitals autoclaved their scalpels, and 13 or 12 per cent employed a germicide marketed by the manufacturer of a certain surgical blade.

In the sterilization of bronchoscopic and eye instruments, the use of chemicals seems to be more popular. Seven institutions reported that they boiled eye instruments in water for 5 minutes, and 2 employed boiling oil.

The great variation in the strength of alcohol employed would appear ludicrous if it were not so serious. For example,

One institution employed 20 per cent alcohol, while 17 reported that 70 per cent alcohol was used. The time element was left unanswered by these 18 hospitals.

How the Other Hospitals Used Alcohol

The following is a summary of the remaining replies: 1 used 100 per cent alcohol for 15 minutes; 12 used 95 per cent alcohol for 15 minutes; 3 used 70 per cent alcohol for 20 minutes; 1 used 95 per cent alcohol for 20 minutes; 1 used 60 per cent alcohol for 30 minutes; 2 used 65 per cent alcohol for 30 minutes; 4 used 70 per cent alcohol for 30 minutes; 3 used 95 per cent alcohol for 30 minutes, and 1 used 75 per cent alcohol for 1 hour.

It would be an excellent thing if some sort of standardization could be secured in this instance. Perhaps some ophthalmologic association or even a national hospital association could lay down standards in this matter. In the meantime, the trend in the sterilization of eye instruments seems to be to immerse them in 95 per cent alcohol for 15 minutes.

The current practice in the sterilization of bronchoscopic instruments also reveals some confusion. In some hospitals, these instruments were boiled in water for periods of time varying from 10 to 30 minutes. Alcohol was used in the following concentrations: 3 used alcohol in 50 per cent concentration; 5 used alcohol in 60 per cent con-

centration; 1 used alcohol in 65 per cent concentration; 17 used alcohol in 70 per cent concentration; 9 used alcohol in 95 per cent concentration; 5 employed an autoclave, and 3 used pure carbolic acid for 20 minutes.

Occasionally compound solution of cresol, cyanide solution or a patented germicide prepared by a house manufacturing surgical blades was employed for this purpose. In 3 instances, formalin, and in one, formaldehyde was used.

Methods Used in Sterilizing Gloves

From the standpoint of the sterilization of gloves, a situation of confusion apparently exists. It seems from this study that the autoclave is the most popular method of sterilizing gloves, having been employed in 94.6 per cent of the cases. The following figures show methods in common use in the majority of the hospitals interviewed: 22 used 15 pounds for 15 minutes; 6 used 15 pounds for 20 minutes; 4 used 20 pounds for 15 minutes; 3 used 18 pounds for 15 minutes; 1 used 15 pounds for 30 minutes; 1 used 15 pounds for 12 minutes; 1 used 19 pounds for 20 minutes; 1 used 10 pounds for 10 minutes; 1 used 12 pounds for 15 minutes; 1 used 18 pounds for 30 minutes; 2 used 15 pounds for 10 minutes.

In 21 institutions, or 20 per cent, gloves were boiled in water. In the majority of instances, the use of 15 pounds pressure for 15 minutes was thought to be safe.

In but few instances was mention made of a specific attempt to sterilize the inside of the gloves. Sixty-nine hospitals or 68 per cent reported the adoption of no special method; 6 placed small gauze sponges inside the gloves before sterilization; 1 turned back the cuffs of the gloves; 1 powdered and folded the gloves with open cuffs; 7 merely powdered the gloves; 1 immersed them in 1/1,000 bichloride for 20 minutes before autoclaving; 2 suggested that gloves be packed loosely and sterilized for an extra amount of time to insure the full ingress of superheated steam. Several hospitals boiled their gloves following operation before autoclaving, and some used compound solution of cresol for this purpose.

It is of the greatest importance that the sterilization of the inside of the glove should be made certain.

No attempt has been made in this article definitely or dogmatically to indicate the proper methods of sterilization. Sufficient evidence, however, has been set forth to demonstrate the trends in the hospital field. This sketch will have served its purpose if it stimulates greater effort to bring about standardization of such practical and important procedures as have been discussed here.

Editorials



A Group of Former Presidents Speak Their Minds

ELSEWHERE in this issue will be found the opinions of several of the most distinguished administrators in the hospital field on a subject of vital interest to every community.

The search for effective methods by which the hospital may meet the cost of carrying an ever increasing free service load is a matter of great concern to hospital workers everywhere. When does the obligation of private charity cease and the responsibility of tax collecting groups begin? What relation does the problem of caring for the unemployed when they are ill bear to that of general unemployment relief? What shall be done when no public institution exists in a community?

All these questions are discussed by Doctors Smith, Babcock, Howell, Sexton, Bachmeyer, MacEachern, Washburn, Burlingham, Doane and Mr. Fesler. Not only because these men, all but one of whom are past presidents of the American Hospital Association and he at present is holding this office, are leaders in their respective communities in formulating policies for the care of the sick, but also because their suggestions contain much of practical use to each reader of THE MODERN HOSPITAL is this magazine immensely gratified to present this brief symposium on this subject.

Are Hospital Superintendents Dilatory?

A STRONG indictment of the careless methods adopted by some executives in handling their mail was recently made by a Midwestern hospital worker who, in seeking a position, had cause for an extensive correspondence with a number of institutional superintendents.

In more than half a hundred instances, it was stated, photographs accompanying efficiency credentials were not returned to the sender although sufficient postage was included. Little wonder the applicant concluded that most administrators are dilatory in their business practices even though such a generalization does not approximate the

truth in regard to all superintendents. Amid the press of attending to the multitudinous details of the day's work, the superintendent may frequently allow his correspondence to accumulate while at the same time he postpones unduly attention to matters of first importance, at least to the members of the community most concerned.

It may seem to many active executives that no time remains for other duties after the day's consignment of questionnaires has been answered. This is a problem, the solution of which challenges the attention of the most astute. Many executives there are who never close their desks at night until all of the day's mail has been answered. Perhaps the roll-top desk should be banned from the hospital office in the same measure as the roller towel has been forbidden in the kitchen. Surely the former may easily serve as a place in which more or less important but time consuming letters of inquiry or application may be conveniently lost. Slovenly office practices strongly suggest careless administrative methods elsewhere.

Group Insurance for Nurses

FEW there are who do not acclaim the wisdom of the practice of obtaining protection against the unexpected losses that are caused by the unpreventable things in life. Guarantees of indemnity, ranging from coverage on the loss of life to the loss of time from work, from the burning or sinking of an ocean liner to the loss of the family silver by theft, may be obtained with ease. Moreover, rates, responding to the pressure of competition and to the more careful actuarial practices of the day, are constantly being revised downward.

Group insurance usually of the straight life type has recently been strongly urged for nurses. There can be little difference of opinion as to the advisability of such a plan from the standpoint of the nurse herself. To make possible the saving of even a fraction of her income is a splendid plan. If she begins to save early in her nursing career a low rate will be obtained, and under the group plan this premium may be still further reduced. But the pupil nurse can hardly purchase the bare necessities of life from her paltry salary and her parents often cannot materially aid her. Perhaps graduate nurses represent the most favorable group for the application of the group insurance plan. No doubt there is a small percentage of pupils who should be urged to undertake this obligation.

Whatever the policy adopted, the hospital should employ no coercion in an attempt to appear mod-

ern and up-to-date. Moreover, it is questionable whether in all cases the hospital should undertake the collection and forwarding of the premiums. If the routine work of the hospital must be slighted because of the assumption of this unusual clerical load, the wisdom of undertaking this task is more than doubtful. Insurance for this group is a good plan, but the hospital's main business is the care of the patient.

Unemployment Relief

AN APPEALING cry for aid has come from the submerged and toiling strata of our civilization. In most instances work and not gratuities has been the burden of the prayers of the masses. Unemployment is a vicious force which by its very weight crushes and destroys human morale, morals and health. Many ills there are that await only the lowered resistance to infection which hunger and deprivation bring to obtain a footing within the body.

Laudable as are the generous responses to this cry for aid, it is a curious fact that to the well unemployed have food and shelter been supplied. But to the call of him who becomes ill, none but the hospital is responsive. Why should not the care of the unemployed who sicken be considered an integral part of the whole unemployed problem? Is there any justice in asking the hospital unaided to carry this load? It is but an act of justice for this institution to share in funds collected in such drives. Surely the man who hungers and is ill presents a more complicated problem than he who hungers only.

The hospital ethically and morally has a right to demand that in plans for emergency relief it should be placed on a prominent, if not a preferred list of participants.

Depreciation

IN CALCULATIONS that involve the cost of service, the deterioration of apparatus and buildings is often omitted. For example, in a comparison of the expense and receipts of the x-ray department, the net profit or loss cannot be computed unless it is considered that the expensive apparatus employed is subject to wearing out and that from 10 to 15 per cent of its cost must be charged off each year to provide for the certain need for new equipment in the future.

Too often favorable cost figures are obtained by the omission of some considerable item from the computation. The well known "good showing"

should not be made in reports to the board of trustees at the expense of veracity or accuracy. To cite figures to suit one's own purpose is a useless if not dishonest practice. The superintendent only deludes himself by so doing. When new apparatus and supplies are required, their purchase price is sometimes not used in computing the annual cost per capita. Such a policy serves inaccurately to off balance the failure to charge annually to expense depreciation on buildings and equipment. It would be a wiser move, it seems, if the executive would attempt a greater accuracy by properly employing both of these figures in arriving at a cost per patient for the year's work.

The existence of careless and unstandardized bookkeeping methods explains in part the present lack of any accurate information throughout the field as to the cost of hospitalizing the sick.

Seasonal Diseases

THE fluctuation that is so universally evident in the use of hospital beds depends in no little measure on the seasonal effect on the incidence of disease. There are other factors of course that determine in some degree the need for the hospital's services. The summer trek toward cooler climes which is a common practice of the urban dweller deprives the doctor's waiting room and the private department of the hospital of many patrons. The absence of doctors on holiday also lowers summer private room averages.

Surgical affections are sensitive in a small degree to climatic changes. But respiratory diseases are prone to be plentiful in spring, fall and winter, and gastro-intestinal infections are favored by the greater consumption of uncooked fruits and vegetables, and the presence of flies and other insects capable of carrying disease germs during the summer months. Fortunately typhoid fever is becoming more rare but even now its appearance in the medical wards is frequent enough to warn of its dangers and to acquaint young physicians and nurses with its treatment. Infantile paralysis seems to display a predilection for warm weather although cases are observed spasmodically throughout the year. Dermatitis as a result of insect bites and of plant poisoning requires usually the services of the out-patient department rather than those of the wards and rooms of the hospital. Even the census of the maternity department is likely to show marked fluctuations, occupancy statistics during the spring and summer months often ranging higher than during the remainder of the year.

If general percentages of bed use are to remain

satisfactorily high, the hospital must be capable of adjusting itself to many peaks in its service load. Fortunately there is a strong tendency for the surgical, medical and pediatric peaks to occur at varying periods of the year. The hospital, realizing the greater possibility of encountering certain forms of disease at some special season, should be prepared for it. Apparatus for the practice of newer methods of treating pneumonia, serum for combating poliomyelitis, serums for treating erysipelas and immunizing against tetanus and isolation quarters for handling winter contagion in the children's ward are but a few of the more necessary requirements for meeting seasonal demands. Forewarned is forearmed in the case of the hospital as well as of the individual.

An Economic Shrinking Violet

WHY should the hospital shun any policy that contemplates the application of business methods in collecting its bills? Is the service rendered of such a doubtful value that it can be considered unjust to press for the payment of these accounts?

In many states it is illegal to endeavor to evade the payment of a hotel bill after accepting shelter and food therein. Why should not at least the private department of the hospital seek such a protection? If better credit making were performed, if each incoming patient were fully advised on his arrival both as to the amount of expense he was about to incur and as to the methods of payment expected, less difficulty would be experienced in collecting some of the hospital's bills for service. Why it is necessary for the hospital's officers to adopt a somewhat apologetic attitude when bills are presented to the patients is beyond the understanding of many.

Not militancy or heartlessness or smallness, but a firm and tactful application of sound business practices will promote better collections and a more general understanding of the hospital and its policies on the part of the community.

Group Medicine in the Hospital

IT IS often but a score of steps from the medical to the surgical wards. Figuratively many leagues separate these departments insofar as the existence of close cooperation between the surgeon and internist is concerned.

The surgeon serenely goes his way of scalpels and tourniquets while the internist, plying stethoscope and laboratory culture tubes, fails to meet

his colleague at the bedside of the patient. Surgical patients with impaired kidneys and infected bronchial mucous membranes are not scrutinized by the internist before they depart for the operating room. The surgeon is a stranger in the medical wards. The interests of the patient, however, demand that these specialists should often meet at his bedside. The surgeon knows little of the advanced methods practiced by the good internist and the latter is unacquainted with the newer developments in surgery. To appoint a medical consultant to the surgical ward is a wise move as is also the reverse procedure of appointing a surgical consultant to the medical ward. No postoperative case of pneumonia or uremia should go long without the advice of the internist. Every gastric ulcer or typhoid patient in the medical ward should be early examined by the surgeon. Moreover, most consultation systems are ineffective and result in but a single observation by the specialist who is called.

For the surgeon and the internist together to lay diagnostic and curative hands on the patient is to hasten his recovery. No one physician is as surely scientifically helpful as two. Shorten the distance between all departments. Insist on consultation in person, not on paper. As a result both the physicians and the patients will benefit.

Taking Stock

INVENTORIES and new calendars go hand in hand. Scarcely have the festivities of the holiday season passed before the stern realities of the new year confront the hospital executive. Now is a time for account taking. What accomplishments of the past twelve months could have been made more effective had greater financial or personnel assets been available? What failures could have been avoided by greater vigilance or initiative?

In the coming months still greater opportunities for service will no doubt be offered because community needs will surely be accentuated. How can better medical and nursing care be provided for less cost? Let us seriously consider the possibilities inherent in the plan of group nursing. Should not the partial payment plan be given a trial? Perhaps a little used private floor should be devoted to semiprivate patients. To cope successfully with to-day's changing conditions demands flexibility and initiative. The opportunities of yesterday are no more—and to-day's tasks are nearly done. The hospital must lead and not follow in thus anticipating the demands of the community of to-morrow.

Is Your Problem Answered Here?

HOW MUCH VACATION SHOULD BE ALLOWED THE HOSPITAL PERSONNEL?

This inquiry has been received from an institution in the Dominion of Canada with a statement of the following details: It is the custom in this hospital to allow four weeks' vacation during the summer and one additional week at or about the Christmas holiday season. An employee of this institution, having reported for duty at the end of September and having expected the full four weeks' vacation, was allowed but one-half of this time because she had not served a full year. Dissatisfaction was thus created and the hospital lost a useful employee.

In general institutions do not adopt as frequently as they should a routine vacation policy. Summer rest periods should not be granted entirely on the basis of the merits of the particular individual affected. A routine that provides a definite vacation for department heads and an equal or graded leave of absence for others in the hospital should be worked out. In this way the setting of a precedent will be avoided and confusion and dissatisfaction on the part of the individual prevented. In this particular hospital a policy that allows department heads including head and floor nurses one month during the summer and a week at Christmas is a generous plan. It is also equitable for the hospital to insist that members of its personnel serve a full year before being granted the privilege of taking their complete vacation period.

In the last analysis a vacation is not only a recognition of a year's faithful service to the institution but also a preparation for the succeeding period of work. When nine months have been served, for example, it seems fair for three-fourths of the vacation period to be allowed. In some institutions a definite rule is established that unless a full year of service has been given to the hospital, but 50 per cent of the total vacation period is granted.

THE MODERN HOSPITAL sees no reason why dissatisfaction should have been caused by granting but two weeks of the total vacation to a worker who has not served a full twelve months. It cautions, however, that when engaging members of the hospital personnel there should be a full understanding not only of the salary to be paid but

also of all the other details of the relationship between the worker and the hospital such as vacation arrangements, living conditions, hours on duty as well as the duties and authority incumbent upon the position that is being filled.

HOW MAY A RADIOLOGIC DEPARTMENT BE ORGANIZED IN A GENERAL HOSPITAL?

A certain Eastern institution, which in the past has not had a radium or deep therapy x-ray machine, has found it possible to add these facilities to its equipment. The board of trustees, however, is afraid that it will be unable to organize a personnel that will be competent to handle the complicated problems incident upon this work. Inquiry is made of THE MODERN HOSPITAL as to the wisdom of attempting this sort of treatment in a general hospital and also as to the possibility of developing a personnel of sufficient skill to carry on this work.

It has been repeatedly remarked in this department that a modern hospital should possess facilities adequate for the treatment of all types of diseases with the possible exception of psychopathic and contagious states. A splendid scientific stimulus is sure to come to this institution if it is able to accept the proffered gift of this x-ray equipment. Situated as it is within a reasonably short distance of a great metropolis this institution should be able to secure the services of a trained radiologist for a short period who would be able to organize a permanent personnel and technique.

Radiology offers a fine specialty opportunity for young physicians and there should be no difficulty in securing the interest of some physician of sufficient scientific bent who will be willing to spend time and money securing information concerning this specialty. The organization of such a department has been found possible under just such circumstances as face this institution, and there surely is no reason why the board of trustees of this hospital should hesitate in accepting such a splendid present because it fears that it may not be able properly to carry on this type of work. A solution of the cancer question is brought nearer when hospitals everywhere endeavor to do their part by performing curative as well as investigative work along these lines.

IS OCCUPATIONAL THERAPY ESSENTIAL TO THE GENERAL HOSPITAL?

The greatest step in advance that occupational therapy has taken in the last few decades is the demonstration of the fact that it has much to offer in the treatment of acute surgical and medical conditions. This branch of work has hitherto been relegated to the chronic hospital for mental diseases. Here it has performed valiant therapeutic services. Nevertheless, it is heartening to walk through many of the acute wards of the general hospital and to note the interest with which these patients are entering into the work prescribed by the occupational therapist. There are still many physicians and administrators who remain unconvinced of the wisdom of organizing such a department in an acute hospital because of the relatively short stay of these patients. And yet, in many bone and joint conditions not only is the morale of the patient maintained by such work but the motion of semi-ankylosed joints is increased and the confidence of the patient restored.

Occupational therapy has come to stay in the acute general hospital and no institution can lay claim to having taken advantage of all the modern possibilities of medicine unless it has organized such a department.

SHOULD THE HOSPITAL PAY THE PHYSICIAN FOR SERVING PATIENTS IN ENDOWED ROOMS?

The endowed room is a losing venture to the hospital. There are thousands of such rooms being maintained to-day for which the hospital years before received from \$500 to \$5,000. The interest upon such sums would hardly provide the light and heat for these rooms. And yet there are institutions which have entered into a contract with the donors and their heirs to maintain such a free space in perpetuity. Some hospitals have an excess of such facilities and are actually maintaining a high grade private service without charge to patients who are able to meet this expense.

Frequently a family endows a room and places in it relatives and friends throughout the major portion of the year. Frequently, a staff physician is expected to treat these patients free of charge. This is an unfair arrangement, not only to the hospital but to the physician. On the other hand, as long as the hospital is losing money thereon it cannot afford to assume any obligation for the payment of a physician's fee.

Either a sufficient sum should be exacted to meet in a large measure the expense of maintaining such facilities or else a period of years should be set

during which the endowment is to be effective. A more logical and, to the hospital, a fairer arrangement would be to permit only the immediate members of a family to be treated in such a room and to allow the hospital to rent this space to others when it is not occupied. A room that rents for six dollars a day, for example, would require an endowment of at least \$30,000 if it is to earn an average of \$1,500 annually. If a smaller endowment sum than this is accepted, then some other arrangement should be made whereby the earning possibilities of this space could be increased.

MAY A CONSULTANT BE CALLED FOR A WARD PATIENT WHO IS NOT PAYING HIS BILLS?

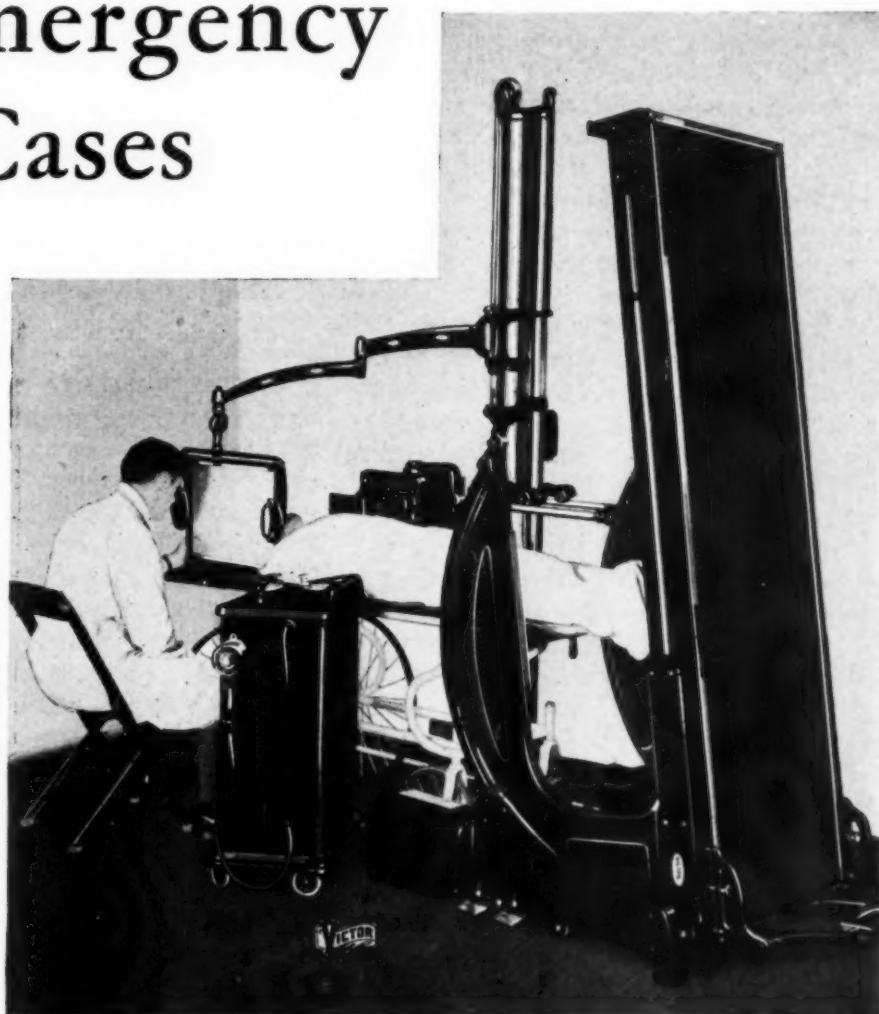
The superintendent in an eastern institution has requested an opinion on this subject. The patient in question was paying the institution on a social service adjustment about one-fourth of the usual ward rate. The amount paid amounted to about one-fifth of the hospital cost. This patient was suffering with a serious blood dyscrasia, and the prognosis was grave. Many staff consultants had been called to consider his treatment and the hospital had not spared money in providing drugs, food and adequate nursing for this patient. Members of the family, however, having heard of a distinguished hematologist, requested that he be permitted to examine the patient and stated also that a not inconsiderable fee was to be paid the consultant.

It seems, on first thought, that such a condition could rarely, if ever, arise. The hospital visiting and consultant staff was comprised of men of experience and of diagnostic and therapeutic skill. They had not spared themselves in the study of this case. The hospital was losing many dollars every week of this man's institutional treatment and yet from somewhere was to be secured sufficient funds to pay a consultant's fee that was far above a minimum charge. The superintendent of this institution, however, could not assume the responsibility of refusing to permit a distinguished physician to examine the patient, even though he was being treated in the ward. It was wisely considered inhumane to deprive the relatives of a hope that they still held for his recovery.

It is questionable whether the adoption of such a flexible policy on the part of a hospital does not set a dangerous precedent for the future. And yet the hospital is in no way responsible for the lack of consideration and the hysteria exhibited by the relatives of a dying patient and should minister to them psychologically as it has endeavored to treat the patient physically.

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WHAT CAN THE HOSPITAL DO WHEN A LOCAL BOARD OF HEALTH INSPECTOR REFUSES TO RECOGNIZE A CONTAGION?

Such a situation rarely arises since local health officers are more inclined to err on the side of diagnosing a contagion as existent even though all of the determining symptoms are not evident. Recently in an Eastern hospital, a case of scarlet fever was detected by resident and visiting physicians, but this diagnosis was not sustained by the physician representing the local health authorities. The case was not a clear-cut one and yet sufficient evidence was at hand by which a diagnosis could be reached. The hospital authorities acted wisely in this instance by treating the case as one of scarlatina. While it is not the best practice to retain such cases in the hospital, yet under the circumstances this was necessary, and when desquamation began the diagnostician was recalled and a diagnosis of scarlet fever was then agreed upon.

The end sought in all health regulations is the protection of the noninfected from the infected. In this case this result was gained even though all the usual steps in bringing it about were not possible. A definite responsibility rests upon the hospital, irrespective of health laws and regulations, to protect its patients from contracting contagious or infectious diseases. In spite of an uncertain diagnosis this obligation requires that every precaution be taken.

WHAT SHOULD BE DONE IF A STAFF PHYSICIAN SENDS A SYPHILIS PATIENT TO THE HOSPITAL UNDER A FALSE DIAGNOSIS?

This is a practical question that has been submitted by the superintendent of a small hospital in New England. It is well known that the average hospital does not possess accommodations for the care of some types of infection and all types of contagion. Some physicians seem to feel that the danger of the transmission of such conditions as erysipelas and venereal disease in its various forms is exaggerated by hospital workers.

In the case cited above, it was well understood by staff members generally that patients with venereal diseases were not to be admitted to the hospital. The particular physician in question, finding it impossible properly to care for the patient at home, deliberately falsified the diagnosis in order to gain his admission to the hospital. Interns, nurses and others were cautioned to keep secret the true condition of the patient, and it was only by accident that the hospital superintendent came in possession of this information. This

occurrence has been met before by hospital administrators. If rules have been adopted fully covering the types of patients to be admitted and if a staff member informed concerning these rules deliberately seeks to prevent their enforcement, there can be but one outcome—the revocation of the rule or the acceptance of the resignation of the physician thus offending. Frequently such a physician is a man of influence and selfishly defies institutional rules to meet his own ends. When such is the case, a firm and unbiased stand by the board of trustees is the only possible course.

HOW CAN IMPETIGO BE PREVENTED IN THE MATERNITY DEPARTMENT?

If a comprehensive and effective answer could be given to this question submitted by a Southern hospital, a great deal of expense and trouble could be avoided in many institutions. The staphylococic infection of the skin which is designated by a varying terminology is a troublesome visitant of the nurseries in maternity hospitals. Indeed, in certain virulent forms this infection may even endanger the child's life.

There are many definite regulations that may be efficacious in preventing this infection. It frequently appears as a hot weather disease. Preventing the maceration of the delicate skin by avoiding irritating diapers, keeping the babies dry and preventing overcrowding are useful precautions. The control of the handling of babies by loving and yet often troublesome relatives is a second step that should be taken. Infection is no doubt brought into the maternity ward in this way. Many pediatricians advise avoiding the use of soap and water during the first two weeks of the child's life and rely upon sterile cottonseed oil for cleansing. Anointing each baby at birth with a 3 per cent ammoniated mercury ointment is advocated by many.

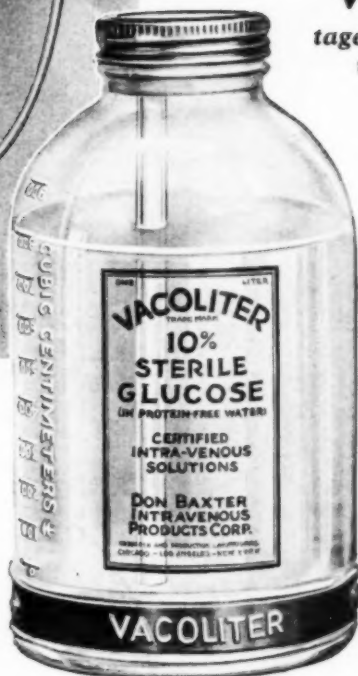
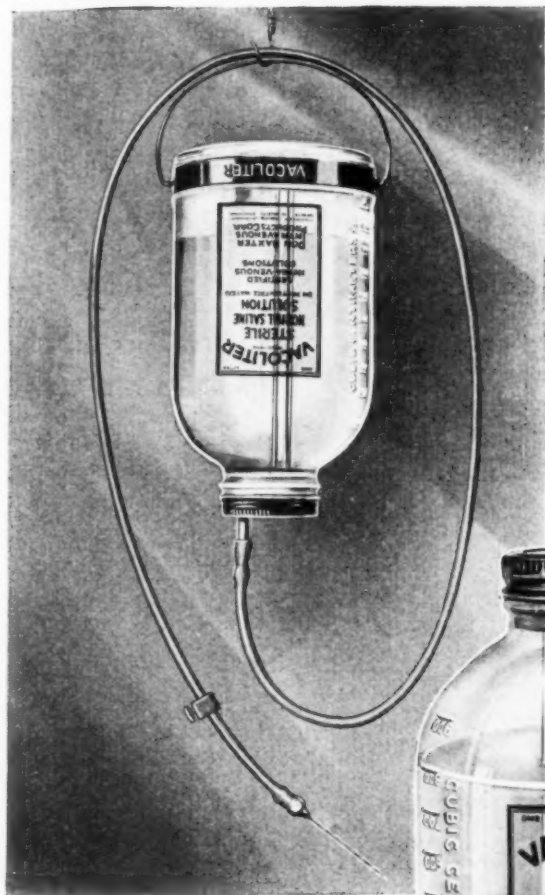
It will be noted that these measures are largely prophylactic. If a case should arise, the only workable plan to adopt is strict isolation of the infected child and the use of certain antiseptic solutions, namely, 3 per cent tincture of iodine, 3 to 5 per cent gentian violet (aqueous solution). The use of the quartz light has also been found satisfactory. It is needless to add that a thorough study of the possibility of the infection of linen in the laundry and the exclusion of any other possible focus of infection should be given much attention. As far as the conduct of the maternity ward is concerned the control of the spread of impetigo lies in the carrying out of the strictest aseptic nursing technique.

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TO WHAT EXTENT SHOULD THE HOSPITAL STAFF BE SELF-GOVERNING?

This question has been asked by the superintendent of an Eastern hospital, in which difficulty is being experienced because of the existence of a certain tendency on the part of the staff to concern itself too intimately with administrative matters. It is a wise policy for hospital staffs to organize themselves thoroughly. This implies that there must be annually selected a president or a presiding officer, perhaps a vice-president and certainly a secretary of the visiting staff. Such a step is conducive to raising the morale of the staff and to placing at the disposal of the board of trustees a method by which opinions may be promptly obtained on hospital medical policies.

The interference of the staff with the appointment of hospital employees should not at any time be countenanced. It is, however, a workable scheme for the trustees of the hospital to require that recommendations for staff appointments pass through the hands of an executive committee and that the staff be held fully responsible for the observations of the hospital rules that have been enacted upon its recommendation. Matters of medical policy should be referred to the staff as a whole or to its executive committee, but such recommendations should be thoroughly considered by staff members before they are submitted to the board.

Staff physicians should be impressed with the fact that their advice is sought and respected. This does not imply, however, that all staff recommendations will receive board approval, nor should it bring about a state of affairs in which staff opinions are forced upon the governing body.

WHEN SHOULD THE TRANSFER OF A PATIENT FROM THE WARD TO A PRIVATE ROOM BE ALLOWED?

An interesting but usually futile attempt is often made by patients and sometimes even by their physicians to avoid the payment of laboratory, x-ray and other bills for specialty services by admitting the patient first to a hospital ward and later transferring him to a private room. This request is frequently made under a variety of guises. The ward may be too noisy for the patient, his relatives cannot visit him there, or one of a dozen other ostensibly reasonable excuses may be given.

This request does not always represent a crude attempt to avoid the payment of a hospital bill. On the other hand, wide-awake administrators have

found it necessary to rule that when a request is made for the transfer of a ward patient to a private room all laboratory and other fees must first be met before this request can be granted. Such fees should be computed at the same rate as would have been the case had the patient occupied the private room from the beginning.

Of course, there are occasions when exceptions to the rigid enforcement of this rule are wise. The executive of the hospital often is willing to rebate such a bill, or even to cancel it entirely under unusual circumstances.

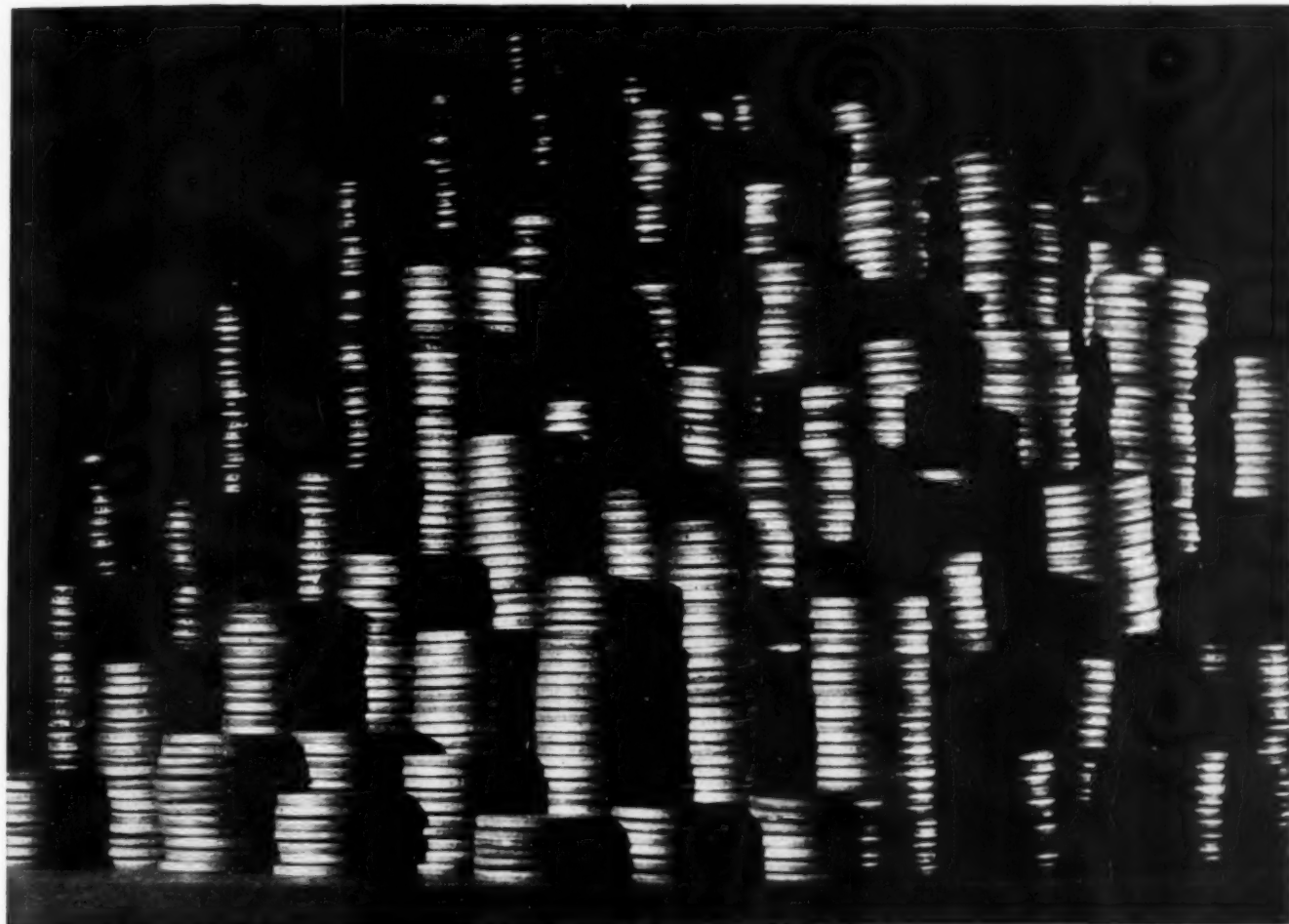
The same may be said concerning the transfer of patients from private rooms to wards. All fees for board should have been met before this transfer is approved. The hospital should be the last type of institution to adopt sharp methods, and yet it has allowed itself to be penalized too long because such practices have been permitted.

SHOULD OUT-PATIENT RETURN CARDS BE GIVEN TO WARD PATIENTS ON DISCHARGE?

Unless the in-patient and out-patient departments are closely connected, reduplication of effort will certainly take place and the incare of patients cannot be as effective as it should be. The out-patient department is a most valuable and important adjunct to in-patient work. Upon the discharge of the patient, every effort must be made to continue the supervision of his home life. This can be done only through a well conducted out-patient department. Unless successful efforts are made to follow the medical condition of the discharged patient by means of return visits to the out-patient clinic, many of these persons will be medically lost and the work of the staff physician brought to naught. On the other hand, a great many are referred to the ward by community physicians. An embarrassing situation arises when the hospital desires to learn the results of treatment in these patients who return to their private doctors instead of to the out-patient departments. It would be obviously unfair for the institution in any way to alienate the loyalty the patient bears to his family doctor. And yet from a practical standpoint, it is almost impossible to secure periodic reports from the practicing physician as to the progress of patients who have been treated at the hospital. Sometimes a social worker or even the medical director of the hospital may gain knowledge concerning the progress of such cases without offense to the family doctor. It is a wise step to bring back to the out-patient department all discharged ward patients as far as possible.

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NEWS OF THE MONTH

A. H. A. Announces Time and Place of Next Convention

The next convention of the American Hospital Association will be held in Detroit during the week of September 12, 1932, it was decided at a meeting of the association's board of trustees, held in Chicago, December 7.

The trustees also granted the request of the Children's Hospital Association of America to be made a section of the American Hospital Association.

Muhlenberg Hospital Celebrates Fiftieth Birthday

Muhlenberg Hospital, Plainfield, N. J., celebrated its fiftieth anniversary on December 1.

It began its record of service in a frame building with wards for men and women in opposite ends of the structure, about twelve beds in all. In the first thirteen months, the hospital admitted forty-two patients, eleven of whom were surgical cases. In the next eighteen months, only sixty-four were received. It was ten years before the number admitted in any one year reached 100. In 1931 as many as 500 patients have been admitted in a single month.

The Muhlenberg Hospital of to-day is adequately equipped to care for 280 in-patients and a much larger number of out-patients in its clinics. It maintains a nurses' training school, a pathological laboratory and an x-ray department.

Marie Louis is superintendent of the hospital.

Grading Committee to Extend Work Two More Years

The Committee on the Grading of Nursing Schools plans to continue its work for two more years if funds can be obtained for that purpose, according to a recent announcement. The committee believes that to stop work at this time would leave several important projects unfinished.

The committee has agreed to make a second grading, which will make it possible for schools

to discover how much progress they have made since the first grading two years ago. This work will start early in January.

A final report is expected to be published near the end of 1933. The report will include a discussion of the problems concerning nursing education as the grading committee has seen them and whatever recommendations the committee feels qualified to make, leading towards the solution of these problems.

A practical handbook on the methods of grading that have been evolved through committee experience will also be published toward the end of 1933.

By carrying through these various projects, the committee believes it will have met, insofar as possible, the chief needs of the nursing and allied professions.

Trustees of A. H. A. Discontinue Services of Library Director

The board of trustees of the American Hospital Association has discontinued the services of the director of the Hospital Library and Service Bureau, due to the present financial situation which urgently indicated the necessity for this action. The board at its meeting in Chicago, December 7, expressed its appreciation of the valuable work done by Charlotte Janes Garrison during the time she has been in charge of the library.

The association took over the library on July 1, 1929, and since that time has appropriated and spent the following sums for its operations: \$4,500 for the six months ending December 31, 1929; \$11,780 for the year ending December 31, 1930 and \$9,000 for the year ending December 31, 1931.

The library committee of the association will continue with its present personnel and the service of the library will continue as in the past. Janet Green will remain as librarian, with her assistants. The direction of the library and its service will continue under the executive secretary of the association, Dr. Bert W. Caldwell. The distribution of the package libraries and all other functions of the library will continue uninterrupted.

Amytal *for Insomnia*

Insomnia due to hypertension, various psychoses, drug addiction, alcoholism, hyperthyroidism, and restlessness due to various causes indicates the use of Tablets Amytal. In conditions where tranquillity and repose are desired Tablets Amytal (iso-amyl ethyl barbituric acid) may be prescribed in doses of $1\frac{1}{2}$ to 3 grains. For sedation in ambulatory cases prescribe Tablets Amytal, Half-Strength, $\frac{3}{4}$ grain.

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NEWS OF THE MONTH (Cont'd)

A. P. H. A. Selects Washington as 1932 Meeting Place

The 200th anniversary of the birth of George Washington will be celebrated during 1932 with appropriate ceremonies in Washington, D. C. To participate in various features of the celebration, many associations have decided to hold their annual conventions in Washington next year. The American Public Health Association, oldest and

strongest organization of its kind on the continent, is one of those. Its sixty-first annual meeting will be held in Washington from October 24 to October 27.

The local committee in charge of local arrangements has already begun to function, under the direction of the general chairman, Dr. William C. Fowler, health officer of Washington.

Additional information may be obtained from the office of the American Public Health Association, 450 Seventh Avenue, New York City.

Coming Meetings

American Association of Hospital Social Workers.

President, Elizabeth Wisner, Tulane University, New Orleans.
Executive secretary, Helen Beckley, 18 East Division Street, Chicago.
Next meeting, Philadelphia, May 14-21.

American Conference on Hospital Service.

Dr. Harry E. Mock, Chicago.
Secretary, Evelyn Wood, 8 South Michigan Avenue, Chicago.
Next meeting, Chicago, February 16.

American Nurses' Association.

President, Elnora E. Thompson, University of Oregon, Portland.
Publicity secretary, Eleonore von Eltz, 450 Seventh Avenue, New York City.
Next meeting, San Antonio, Texas, April 11-16.

Annual Congress on Medical Education, Licensure and Hospitals.

Next meeting, Chicago, February 15.

Iowa Hospital Association.

President, Robert E. Neff, University of Iowa Hospitals, Iowa City.
Secretary, Clinton F. Smith, Allen Memorial Hospital, Waterloo.
Next meeting, Sioux City, March 9-10.

National Methodist Hospitals, Homes and Deaconess Work Association.

President, Dr. John G. Benson, Methodist Episcopal Hospital, Indianapolis.
Secretary, Guy M. Hanner, Beth-El General Hospital, Colorado Springs, Colo.
Next meeting, Chicago, February 10-12.

New England Hospital Association.

President, James A. Hamilton, Mary Hitchcock Hospital, Hanover, N. H.
Secretary, Dr. Morgan J. Rhees, Massachusetts General Hospital, Boston.
Next meeting, Boston, February 12-13.

Hospital Association of New York State.

President, Carl P. Wright, Syracuse General Hospital, Syracuse.
Secretary, Julian Funt, Beth Israel Hospital, New York City.
Next meeting, May 5-7, New York City.

North Carolina Hospital Association.

President, Dr. Harold Glascock, Mary Elizabeth Hospital, Raleigh.
Secretary, Edwin G. Farmer, Carolina General Hospital, Wilson.
Next meeting, Richmond, Va., May 17-19.

Northwest Hospital Association.

President, Carolyn E. Davis, Good Samaritan Hospital, Portland, Ore.
Secretary, Mrs. Cecile Tracy Spry, General Hospital, Everett, Wash.
Next meeting, Seattle, January 18.

Ohio Hospital Association.

President, Dr. C. S. Woods, St. Luke's Hospital, Cleveland.
Executive secretary, John R. Mannix, University Hospitals, Cleveland.
Next meeting, Akron, March 15-16.

Hospital Association of Pennsylvania.

President, M. H. Eichenlaub, Western Pennsylvania Hospital, Pittsburgh.
Secretary, Howard E. Bishop, Robert Packer Hospital, Sayre.
Next meeting, Pittsburgh, March 15-17.

South Carolina Hospital Association.

President, F. O. Bates, Roper Hospital, Charleston.
Secretary, H. H. McGill, Columbia Hospital of Richland County, Columbia.
Next meeting, Richmond, Va., May 17-19.

Texas State Hospital Association.

President, Robert Jolly, Baptist Hospital, Houston.
Secretary, Joe F. Miller, Jefferson Davis Hospital, Houston.
Next meeting, Dallas, April 8-9.

Virginia Hospital Association.

President, Dr. Knowlton T. Redfield, Jefferson Hospital, Roanoke.
Secretary, M. H. Coleman, Jr., Johnston-Willis Hospital, Richmond.
Next meeting, Richmond, May 17-19.

Western Hospital Association.

President, Dr. B. W. Black, Highland Hospital, Oakland, Calif.
Secretary, Mrs. Lola M. Armstrong, Los Angeles.
Next meeting, Salt Lake City, Utah, June 14-16.



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NEWS OF THE MONTH (Cont'd)

New York Hospitals Urged to Work for Compensation Legislation

Now that the right of private and municipal hospitals to charge for the actual cost of caring for workmen's compensation cases has been legally established by a decision of the appellate division, New York State, the hospitals of New York City are urged to work at the coming session of the legislature for laws that will amend and clarify the compensation act so that full reimbursement of hospitals by the insurance carriers of such cases shall become a statutory obligation.

This is in substance an appeal by Howard S. Cullman, president, Beekman Street Hospital, New York City, to the United Hospital Fund, the accredited agency of the New York City hospitals. Mr. Cullman is chairman of the governor's committee to review hospital problems connected with compensation.

Mr. Cullman reviews the court's decision as follows:

"In an action brought by the Utica Mutual Insurance Company to test subsection thirteen of the compensation act, the opinion of the court clearly defines the intent of this ambiguous passage. This decision is of prime importance to every hospital in New York State.

The Ambiguous Passage

"The doubtful clause in question reads: 'All fees and other charges shall be limited to such charges as prevail in the same community for similar treatment of persons of a like standard of living.' Interpreted by insurance carriers in the past to justify the payment of no more than the ward charity rate for compensation cases, this section has been the basis of the insidious pauperization of the victims of industrial accidents. That this practice was far from the intent of the compensation act was lucidly demonstrated by the attorney general who declared in his brief that 'to compel the hospital to charge less (than cost) would be to throw the burden of the care of persons injured in industry upon the hospital instead of upon the employer and insurance carrier where it justly belongs.

"The cost of caring for such a patient is rightfully assessed against the injury which disabled him and should be assumed by the carrier who,

engaged in business for profit, took the insurance and the just obligations that went with it. The institution not in business for gain, but engaged essentially in rendering aid to the poor and needy cannot under any theory of law of equity be made to participate in the same. The intent of the donor or benefactor would have to be flagrantly disregarded, trust funds diverted and their wholesome objective thwarted, while the insurance carrier is taken under the wing of philanthropy.'"

Paul Fesler Heads Committee on Veterans' Hospitalization

Paul H. Fesler, superintendent, University of Minnesota Hospital, Minneapolis, is chairman of a committee appointed by the trustees of the American Hospital Association to seek the further hospitalization of war veterans in civilian hospitals, according to resolutions adopted by the board of trustees at a meeting in Chicago, December 7. Other members of the committee are Dr. N. W. Faxon, director, Strong Memorial Hospital, Rochester, N. Y., and Col. Hugh Scott, superintendent, Edward Hines, Jr. Hospital, Hines, Ill.

The resolutions adopted by the trustees request that the plan for building additional hospitals by the Veterans' Bureau for the hospitalization of veterans be discontinued and that the bureau utilize hospital facilities of civilian hospitals.

The committee will present the resolutions to the rehabilitation committee of the American Legion.

Congress on Urban Hygiene to Meet in Lyons, France

Lyons, France, has been chosen as the seat of the Third International Congress of Sanitary Technics and Urban Hygiene, to be held March 6 to 9, 1932. The congress will coincide with an international exhibition, which will take place from March 7 to 20 during, and in the buildings of, the Lyons Fair. All information may be obtained on request to Monsieur le Docteur Garin, Professeur Agrégé à la Faculté de Médecine, Rue Ménéstrier, Lyons.

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NEWS OF THE MONTH (Cont'd)

Hospital Workers at University of Chicago Share in Health Service

The board of trustees, University of Chicago, has approved a comprehensive health service program for the staff and employees of the clinics group which will serve the 900 members of the group.

Those eligible for participation are members of the staff and employees on the regular pay roll in the following departments and administrative units: department of medicine; department of obstetrics and gynecology; department of pathology; department of pediatrics; department of surgery; Albert Merritt Billings Hospital; Max Epstein Clinic; Bobs Roberts Memorial Hospital for Children; Home for Destitute Crippled Children; Chicago Lying-in Hospital and Dispensary; Country Home for Convalescent Children; Sprague Memorial Institute; Lasker Foundation for Medical Research; Douglas Smith Foundation for Medical Research; appointees and employees under various research funds, working in the clinics group.

The health service program will be administered by the University Health Service, under the direction of Dr. Dudley B. Reed. The plan includes: (1) public health features, including preliminary examinations and control of communicable diseases, the expense of these features to be borne entirely by the constituent organizations; (2) medical and hospital service to individuals for which the contributions of \$1 a month required of participants will be paid into a fund which will be used only for meeting the costs of medical and hospital service to the individual participants in the plan. This part of the plan is therefore in effect a health insurance plan, with all of the benefits from contributions reverting to those participants who are in need of medical and hospital service.

How Personnel Participates in Plan

Participation in the plan is to be obligatory for all staff members and employees in the clinics group under the following conditions: for all new appointees and reappointments with no exceptions; participation in the public health aspects of the plan (examination, immunizations, etc.) obligatory for all present employees, with no exceptions;

full participation in the plan, including monthly payments, to be required of all present staff and employees, unless specifically exempted.

The conditions governing participation of staff members of constituent organizations within the clinics group will be determined by the appropriate boards. The Home for Destitute Crippled Children has already adopted the plan. Until final action is taken by other boards, participation of members of their groups is optional.

The cost of the plan to each individual participant is fixed by the board of trustees at \$1 a month, deductible monthly from salary payments. Deductions will be made from the date the plan is actually put in effect.

This plan, which has been a subject of study for more than a year, is devised to provide for the workers' needs, for their protection from illness and for their financial relief in case of illness.

Baltimore Emergency Hospital to Open February 15

A new emergency hospital will be opened February 15 in the Curtis Bay section—the principal industrial district—of Baltimore, Md. It is to be known as the Brooklyn and Curtis Bay Emergency Hospital and will have a capacity of 100 beds with dispensary, maternity and accident wards. Dr. Arthur G. Barrett is president of the new hospital.

The Curtis Bay Hotel has been taken over and remodeled into a completely equipped hospital. Particular attention has been paid to plans to provide low cost private rooms and medical attention.

New Eye Hospital Is Planned for Philadelphia

Construction will start shortly on the new Willis Eye Hospital, Philadelphia. It is to be built at a cost of \$1,064,200 and the contract calls for the completion of the 200-bed hospital in 336 calendar days.

The new hospital will be eight stories high, of steel and concrete construction with brick, marble and stone facing and trim. It is designed to be the most complete of its kind in the world.

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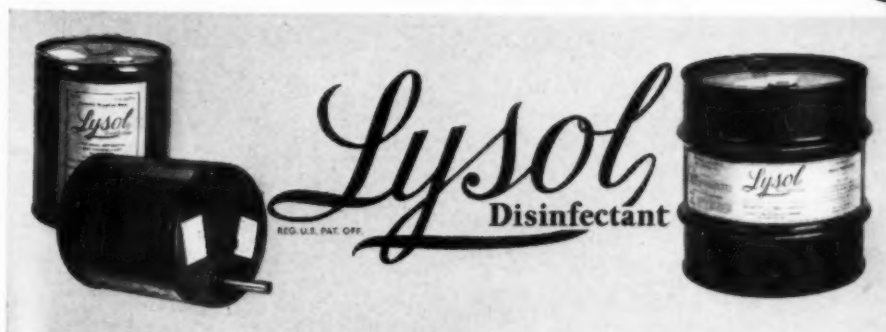
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NEWS OF THE MONTH (Cont'd)

A. H. A. Donations to Grading Committee Are Terminated

The American Hospital Association has discontinued its contributions to the Committee on the Grading of Nursing Schools. With this year's donation to the work of the committee, the association has contributed \$4,000 over a period of five years—the time set for the committee to accomplish its program.

This action was taken at the recent meeting of the board of trustees of the association.

Contributions made by the association since 1927 were listed as follows: \$500 in 1927; \$1,000 in 1928; \$1,000 in 1929; \$1,000 in 1930 and \$500 in 1931.

Iowa Dietetic Association Holds Meeting

The Iowa State Dietetic Association, recently affiliated with the American Dietetic Association, met in Des Moines, November 13.

Speakers included Frances Swain, representative of the home economics association; Dr. J. T. Strawn who gave a paper on the dietary treatment of peptic ulcers; Dr. C. H. Sprague who discussed recent ideas in nutrition; Dr. Eli Grimes who read a paper on iodine deficiency, and Miriam Lowenberg who told of experiments in food preparation for the small child.

Colorado Urges Hospitalization of Veterans in Civilian Hospitals

The following resolution was adopted by the Colorado Hospital Association at Colorado Springs, Colo., November 11, 1931:

Whereas, The Colorado Hospital Association in no manner disapproves of the program of the national government in hospitalizing and providing medical care to the veterans who have served in the United States military forces, including cases of disability other than that attributed to the hazards of service; and offers no protest against the hospitalizing of such cases in the already established government hospitals, either

under the veterans' or military control; and

Whereas, It is known that, in order to carry on such a program, provision must be made for greater bed capacity than is now available in existing veterans' and military hospitals, but

Whereas, There are enough beds available in the already existing, first-class, approved, civilian hospitals adequately to provide facilities for the hospitalization of the veterans who at present cannot be cared for in the already established veterans' hospitals; and

Whereas, These civilian hospitals are willing to care for these said veterans in their home communities, at an expense to the government less than the cost of building, equipping, and maintaining the proposed additional hospitals;

Be it therefore resolved, That the Colorado Hospital Association protest against the further construction and establishment of veterans' hospitals, and request that the veterans who are to be treated, for whom there are not available beds in the already established government hospitals, be assigned to the various first-class civilian hospitals for their hospital care;

Be it further resolved, That the Colorado Hospital Association heartily endorse the resolution of the American Hospital Association relative to this subject.

A. C. of S. Chooses St. Louis for Meeting, September 17-21

St. Louis has been chosen as the place and September 17 to 21 have been checked on the calendar as dates of the fifteenth annual meeting of the American College of Surgeons. A large section of the program will be devoted to the Hospital Standardization Conference.

Boston Floating Hospital Is Host to New England Pediatricians

A clinical meeting of the New England Pediatric Society was held December 11 in the Jackson Memorial, the new building of the Boston Floating Hospital, Boston. The meeting, presided over by Dr. Elmer W. Barron, physician-in-chief, was attended by over fifty prominent pediatricians.



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NEWS OF THE MONTH (Cont'd)

New Officers Named for California Occupational Therapy Group

New officers of the California Occupational Therapy Association are: president, Mary C. Rixford, Fairmont Hospital, San Leandro; vice-president, Ruth M. Gilgen, Olive View Sanatorium, Olive View; secretary-treasurer, Milward Holden, U. S. Marine Hospital, San Francisco.

The eighth annual meeting of the association was held in Los Angeles recently. The meeting was featured by a display of patients' work from various state hospitals and institutions.

State Association Heads to Meet With A. H. A. Trustees

Presidents of the state and regional hospital associations of the United States and Canada have been invited to meet in conference with the board of trustees of the American Hospital Association, on Saturday, February 13, before the regular meeting of the board on Monday, February 15, and before the annual congress on Medical Education, Licensure and Hospitals of the American Medical Association which begins February 15.

Sisters at St. Elizabeth Hospital Distribute Christmas Baskets

The nursing supervisors and several of the alumnae members of St. Elizabeth Hospital, Chicago, celebrated Christmas by raising a fund that was presented to the Sisters in charge of the hospital to be used for distributing Christmas baskets to the poor. Because of this generosity and the generosity of others, the Sisters were able to give many baskets of food a day during Christmas.

Northwest Association to Meet in Seattle, January 18

The Northwest Hospital Association will meet in Seattle, Wash., January 18.

The association waived its last two meetings to support the Western Hospital Association but answers to a questionnaire recently sent to the

members show that they are almost unanimously in favor of having separate association meetings.

Carolyn E. Davis, superintendent, Good Samaritan Hospital, Portland, Ore., is the president of the association.

Chicago Dietitians See Meat Cutting Demonstration

A meat cutting demonstration under the direction of Arnold Shircliffe, catering manager of the Belden Stratford Hotel, Chicago, was the feature of the meeting of the Chicago Dietetic Association, December 16. A steer, a lamb and a hog, were used for the demonstration.

A business meeting followed at which officers were elected for the coming year as follows: president, Sarah Elkin, Mandel Clinic, Michael Reese Hospital; vice-president, Lida Jamison, the Chicago Dietetic Supply House; secretary, Beulah Hunzicker, Presbyterian Hospital; treasurer, Grace Myers, Cook County Hospital.

New Hospital to Accommodate 150 Cardiac Children

The board of directors of Irvington House, a home and hospital for cardiac children, Irvington-on-the-Hudson, about thirty miles from New York City, has decided to proceed immediately with the construction of a new hospital planned to accommodate 150 children. The preparation of plans has been entrusted to Sloan and Robertson, architects, with whom Dr. S. S. Goldwater is associated as consultant.

Norwood Hospital Acquires Group Insurance Policy

A group life insurance policy has recently been acquired for the employees of the Norwood Hospital, Birmingham, Ala. Sixty-seven workers are insured under this arrangement and the total coverage involved is \$106,000.

Insurance is granted in amounts ranging from \$1,000 to \$3,000, according to rank or the position held, and because this policy is of the contributory type, the workers share in the premiums.

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PERSONALS

DR. D. D. CHAPMAN, superintendent, Spencer State Hospital, Spencer, W. Va., has resigned. He is succeeded by DR. BARRICK SAMUEL RANKIN, Kingwood, W. Va.

THE REV. TITUS POHL, pastor of the Swedish Evangelical Mission Church, Des Moines, Iowa, has been appointed superintendent, Evangelical Covenant Hospital, Omaha, Neb. He succeeds the REV. THEODORE YOUNG.

BERDINE MOORE, formerly with All Saints' Episcopal Hospital, Fort Worth, Tex., is the newly elected superintendent, Deaf Smith County Hospital, Hereford, Tex.

CAPT. PERCIVAL S. ROSSITER, who has been commanding the U. S. Naval Hospital, New York City, since May 8, 1929, will command the U. S. Naval Hospital, Washington, D. C., beginning January 8.

ROBINSON E. ADKINS, administrative officer, Veterans' Hospital, Rutland Heights, Mass., has been elected director of hospitalization, Haverhill, Mass., for one year, beginning January 2.

FRANCES P. WEST, formerly superintendent at the Charlotte Hungerford Hospital, Torrington, Conn., is now superintendent at Middlesex Hospital, Middletown, Conn.

MAMIE R. ODDEN is the new superintendent of Worthington Clinic Hospital, Worthington, Minn.

SISTER M. DAMIAN has been appointed as superintendent of St. Joseph's Infirmary, Houston, Tex. She was formerly superintendent of Hotel Dieu, Beaumont, Tex.

MRS. F. C. FOUSER, formerly with the Western Electric Company Hospital, Chicago, is now superintendent of Wesson Memorial Hospital, Springfield, Mass.

MARJORIE M. IBSEN, for five years assistant superintendent, Highland Park Hospital, Highland Park, Ill., has recently been made superintendent, succeeding MARGARET JOHNSON, resigned.

KATHERINE R. YOCUM is the new superintendent of St. Paul Hospital, St. Paul, Minn. She was formerly director of nursing education at Lancaster General Hospital, Lancaster, Pa.

DR. RALPH RUSSOMANNO is the superintendent of the newly opened Columbus Memorial Hospital, Newark, N. J.

JESSIE DAVIDSON has been named superintendent, Monongahela Memorial Hospital, Monongahela, Pa., succeeding JACOB P. BLANK, resigned.

E. H. TAYLOR, who was formerly with the Boston Lying-In Hospital, is now superintendent of the Franklin Hospital, Franklin, N. J.

MADELINE V. WILLIAMS has recently succeeded MARIE L. BAPTIST as superintendent of the Retreat for the Sick Hospital, Richmond, Va.

DR. I. R. WAGNER has assumed his duties as medical officer in charge of U. S. Veterans' Hospital No. 88, Memphis, Tenn., succeeding DR. EUGENE DAVIS who assumes a similar position at the Veterans' Hospital, Fort Lyon, Colo.

DR. WILLIAM J. TIFFANY, superintendent, Kings Park State Hospital, Kings Park, N. Y., has been named superintendent of the new Pilgrim State Hospital, Brentwood, N. Y.

KATHRYN E. KRAUSS has recently been appointed as superintendent of the Andrew Kaul Memorial Hospital, St. Marys, Pa.

Final Report on Costs of Medical Care Scheduled for 1932

The final report of the Committee on the Cost of Medical Care, to be published in 1932 after five years' investigation, "will provide for the first time a really scientific basis for attacking the problem of proper medical care and protection for all," Dr. Ray Lyman Wilbur, secretary of the interior, declared in a statement to the committee during its two-day meeting which concluded December 19.

Secretary Wilbur, who is chairman of the committee, which is nongovernmental in character, further pointed out that the studies will present "a cross section of the whole medical situation in the country."

The committee was formed in 1927 and includes sixteen physicians in private practice; six representatives of the field of public health; twelve representatives of medical and dental schools, hospitals, nurses and the American Medical Association; six economists, and ten representatives of the public.



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NURSING AND THE HOSPITAL

Conducted by M. HELENA McMILLAN, R.N.
Director, School of Nursing, Presbyterian Hospital, Chicago

Measuring Nursing, Quantitatively and Qualitatively*

By BLANCHE PFEFFERKORN, R.N.
Philadelphia

If we enlarge ever so little our sphere of light, we increase infinitely our points of contact with it.
—Spencer.

A FUNDAMENTAL factor in the administration of a hospital nursing service is the bedside nursing personnel or, more accurately stated, the hours required to give the proper bedside nursing care to patients. Not infrequently a considerable discrepancy exists between the bedside nursing hours provided and the bedside nursing hours required.

Several causes underlie this condition. Increased personnel increases the cost of operation, and hospitals for the most part are administered on limited budgets. The hospital has been slow to adopt scientific methods. Some agreements on the ratio of nurses to patients have been reached for the four basic services, but these agreements are largely opinion, lacking scientific basis and experimental support.

Probably one of the chief obstacles to the development of methods for the measurement of nursing time needs has been the persistence of the idea that a nursing yardstick is impossible and impracticable. This may be due to a mistaken concept of the purpose, values and uses of time studies. True, each patient presents individual needs, both physically and mentally, and equally true, each nurse differs in speed and precision of thinking and acting. Yet measuring techniques have been evolved for functions of a more uncertain and intangible nature than nursing.

Too frequently time studies are conceived in purely quantitative terms. More emphasis is needed on the necessity of providing enough time

to make possible a good quality of nursing. The first premise of a valid time study is good nursing in the sense of average performance. This is the essential criterion by which the study should be judged.

In a study of nursing time requirements it is important to remember that the average is the measure sought—average patient reaction, average nursing ability, average time needs—and that averages must be based on reliable statistical and professionally interpreted data. Further it should be kept in mind that a shortage of two hours on a service requiring 100 hours is not fundamental, but that a shortage of twenty hours on the same service may seriously affect the quality of its nursing. The purpose of a time study is not to disclose fine and theoretical discrepancies but to provide an index for determining within reasonable limits the nursing time required to do good nursing. This index should be finally expressed in practical, easily usable terms, such as ratio of nurses to patients, or per patient load requirement, with an accompanying statement defining in detail the hospital and nursing conditions under which these results were obtained.

The Ratio of Nurses to Patients

If 1 or 2 nurses are responsible for 1 patient (the "specialled" patient) the time factor practically ceases to be a consideration. In 24 hours this patient will be provided with 18 to 24 hours of nursing time, which frequently is much more than is required. On a hospital service where the bedside nurses range from 1 nurse to 3, 4, 5, or more patients, a much more complex, unregulated and unbalanced situation exists. The returns from a questionnaire study of a selected group of in-

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stitutions made in 1927 by the Committee for the Study of Nursing Education in Colleges and Universities of the National League of Nursing Education, disclosed a variation in the ratio of nurses to patients, not explainable either by the type of patient or by the hospital conditions.

If Hospital A maintains a ratio of 1 bedside nurse to every 3 patients, and Hospital B, similar in type and operated under comparable conditions, a ratio of 1 bedside nurse to every 6 patients, obviously Hospital A provides twice the amount of nursing time per patient of Hospital B. Apply

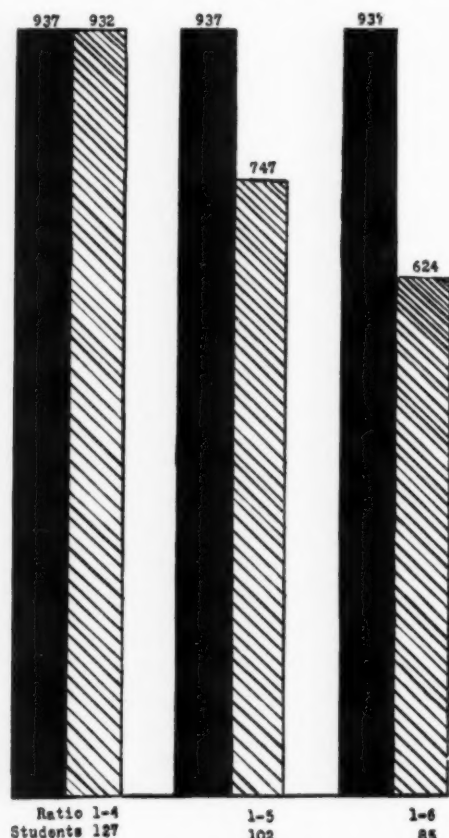


Diagram 1. Total load hours required in twenty-four hours and total nursing hours provided in twenty-four hours.

this ratio relationship to the carrying out of procedure. Assume that Hospital A supplies approximately the required nursing time and that an average of 40 minutes is necessary to give a cleansing bath. On the basis of its staffing, 20 minutes only are available for this bath in Hospital B. What must happen? If there is only staff enough to allow 20 minutes to be spent in a 40-minute procedure, good nursing is prevented.

A scientifically executed time study becomes in effect a fine-tooth comb survey of the nursing service and, if a school is operated, of the nursing practice program of the student nurse. Techniques are subjected to critical examination, student ward experience and supervision are analyzed and

ward working conditions are scrutinized. These perhaps are the more important by-products; many more inevitably appear.

Broadly approached, the problem of nursing care time studies in any institution is concerned with the nursing care needs of the patients in that institution. As far as I know, the first consideration of the question on an actual time measuring basis was given in 1921 by Elizabeth A. Greener, superintendent of nurses, Mt. Sinai Hospital, New York City, at the suggestion of Dr. E. H. L. Corwin, executive secretary, public health committee, New York Academy of Medicine. Miss Greener's study¹ included a mixed group of patients, two medical and two surgical (one man and one woman on each service), and three children. Nineteen student nurses engaged in the project. According to Miss Greener's findings the number of nurses necessary to care for such a group of patients over a 24-hour period with an 8-hour service is 1 student nurse to every 1.7 patients.

What Earlier Studies Revealed

In 1927, Gladys Sellev and two other nurses at the Babies' and Children's Hospital, Western Reserve University, Cleveland, published three schedules² showing the number of hours of nursing required for three average pediatric patients, aged one year, five years and ten years. The details and scope of the work are not given.

Other reports of efforts to gather factual information on nursing time requirements have appeared in professional journals in the last several years, the majority of these studies representing a 24-hour picture of one or more patients. The surgical nursing study made by Margaret Tracy at the Yale University School of Nursing in 1928 is the most comprehensive and scientific of such published investigations to that date.³

In September, 1930, a quantitative and qualitative nursing study to cover a year was undertaken at Bellevue Hospital, New York City. It was financed by the board of women managers of the Bellevue school of nursing, for the definite purpose of applying the findings to the administration of the nursing service and the supervision of the student nurse. In the development of the study a new technique was evolved. While the principles of the technique are relatively simple, the application requires thoroughness, accuracy and thoughtful interpretation for reliable and use-

¹Greener, Elizabeth, A Study of Hospital Nursing Service, THE MODERN HOSPITAL, Jan., 1921, p. 28.

²Sellew, Gladys; Ovens, A., and Ruppert, E., Some Time Studies, Amer. Jour. of Nursing, Feb., 1927.

³Bul. No. 1, Yale University School of Nursing, New Haven, Conn., 1928.

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ful results. As a method, it should serve, with the proper adaptations, for securing the nursing requirements in a visiting nursing association as well as in a hospital. Because of the interest manifested in the study and in the hope that it may be useful to other organizations desiring to make similar investigations, it is planned to publish the details of the technique in book form at an early date. The accompanying diagrams are based upon findings of the Bellevue study.

The average required nursing load over a 24-hour period (from 7 a.m. to 7 a.m.) on the medical service at Bellevue for six months (from

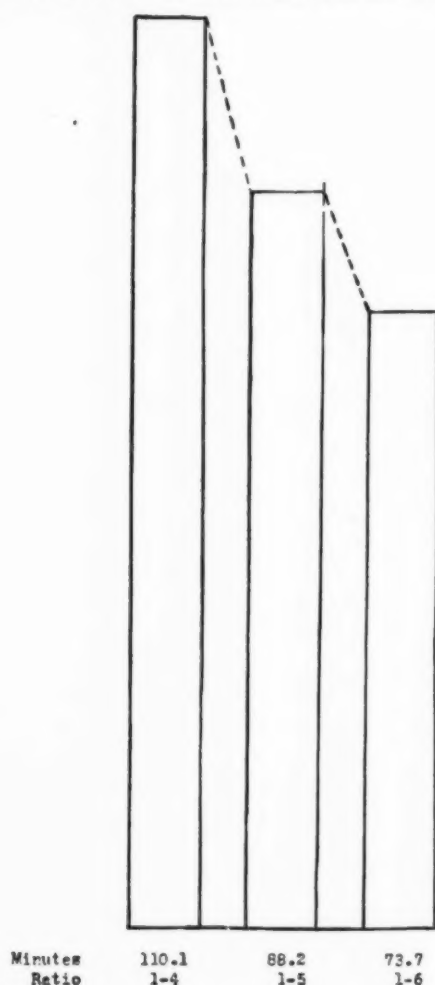


Diagram 2. Per patient load time provided in twenty-four hours.

December, 1930, to May, 1931) was 937 hours with an average daily census of 508.2 patients. Upon the basis of the hours provided by the student bedside nursing staff (students average 7.1 hours daily and 8.6 hours at night) the required ratio of student nurses to patients for the 24-hour period (7 a.m. to 7 a.m.) is 1 to 4. This ratio is found by dividing the nursing load for the day period (767.9 hours) by 7.1; the nursing load for the night period (169.8 hours) by 8.6.

The sum of the results, 127.9, is the number of bedside student nurses required to staff the service. If the patient census, 508.2, is then divided by 127.9, the ratio 1 to 4 is obtained.

Diagram 1 shows the required nursing load hours as covered by the ratios of student

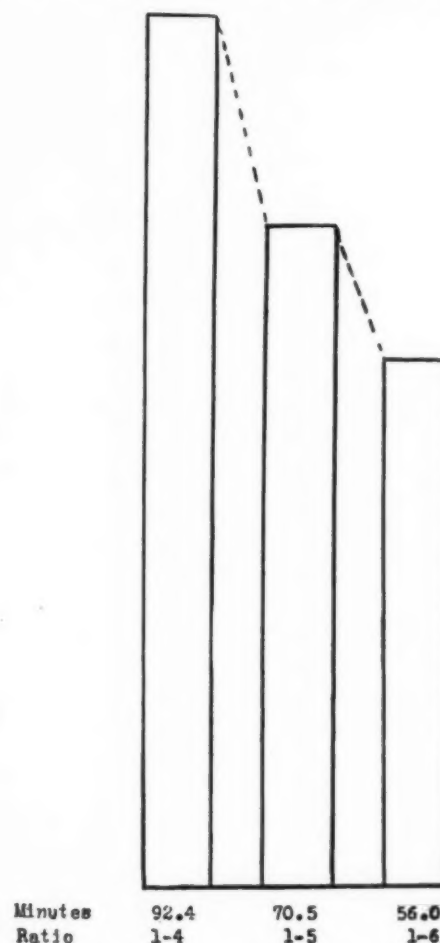


Diagram 3. Direct bedside care per patient in twenty-four hours.

nurses to patients 1 to 4, 1 to 5 and 1 to 6. The load hours required and the nursing hours provided with a ratio of 1 to 4 balance within 5 hours, a negligible difference on a load of such size. With the 1 to 5 ratio, 190 nursing hours less (or 20.3 per cent) are provided than are required.

Translating the total load on the medical service into per patient load requirement, the average load per patient in 24 hours is 110.7 minutes, which will be available within 0.6 of a minute with a 1 to 4 ratio of student nurses to patients. If the ratio is reduced to 1 to 5 the per patient time provided is 88.2 minutes or 22.5 minutes less than is required. If the ratio is still further reduced to 1 to 6, the per patient time provided is 73.7 minutes or 37.0 minutes less than the required per patient load (Diagram 2).

In the per patient load requirements are in-

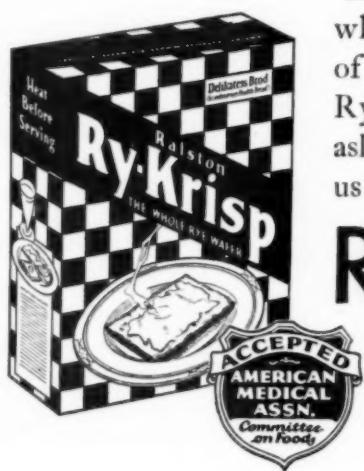
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cluded the direct bedside care and the general ward activities, such as answering the telephone, writing reports and talking to visitors, performed by the bedside nursing staff. These general ward activities average 17.7 minutes per patient in 24 hours, so that if 17.7 minutes are subtracted from the per patient load requirement (110.7 minutes) the remainder, 93.0 minutes, is the time required for the direct bedside care of the patient. With a 1 to 4 ratio the average direct bedside nursing care provided per patient is 92.4 minutes in 24 hours; with a 1 to 5 ratio 70.5 minutes are provided per patient; with a ratio of 1 to 6, 56.0 minutes are provided per patient (Diagram 3).

For the proper interpretation of any given ratio it is necessary, as stated in a preceding paragraph, to know the hospital and nursing service conditions under which that ratio obtains. A number of factors influence the ratio. Among the more important are the duties of the maids and orderlies, directly in connection with the patients and in the performance of ward housekeeping functions; the hours of bedside care upon which the ratio is based; the type of patient. Such information enables other hospitals to determine whether or not the ratio is applicable to the nursing service of their own institutions.

The Deaconess Hospitals of Holland and Their Work

An article on the new Deaconess Hospital in The Hague by M. A. and J. Van Nieukerken, architects, which appears in a recent issue of *Het Ziekenhuiswezen* points out that the deaconess institutions in Holland have a double purpose.

The first of these consists in the education of pupil deaconesses, joining them with the older Sisters in a mother house. The second is the management of hospitals. Both of these purposes are interdependent, although the training of students for district nursing and hospital service seems to be the more important in deaconess work in accordance with the founder, Pastor Fliedner of Kaiserswerth (near Düsseldorf), Germany. For this reason many deaconess institutions in Holland still have a pastor at the head of the management though there is a growing tendency to replace him by a medical man.

On a magnificent plot at the foot of the dunes, on the outskirts of the town near a large villa park, the mother house and hospital have been built together, forming on the plan the figure of the letter H, the right vertical of which is divided

in two with a little separation. Thus the kind of construction is of the corridor pavilion variety. The chapel is in the middle of the building complex, four stories high and is representative of the old Dutch architecture with its sharp roofs, attic windows and in the lines of its façade.

The hospital has accommodations for 164 patients including those who are chronically ill. Some of these are in private and in semiprivate rooms and some are in wards that have a maximum capacity of twelve beds. For the nursing care of these patients there are 120 deaconesses and pupils.

The editor of the *Dutch Hospital Review*, in commenting on this article, remarks in passing that this hospital will be one of the attractions for the delegates to the third international hospital congress which he expects will be held in The Hague.

Another contribution to the hospital work of Holland was the opening of a new deaconess institution in Flushing, the southern harbor of Holland on the Isle of Walcheren. This hospital was also built in the mixed corridor pavilion style with wings that diverge in six directions. The cost of the building was the gift of one donor.

In commenting on this contribution, the editor writes: "Public interest in the hospitals of Holland is far less than one finds in America or in England, to my mind a result of political meddling in hospital matters which prevents the development of private initiative in a large way. Of course there are many private hospitals in our country, mostly of the ecclesiastic type, but they are superseded in numbers by the public hospitals. Moreover, our private institutions lean heavily on public funds in their management."

A Hospital School for Chronically Sick Children in Lisbon

A kindergarten-elementary school is maintained by one of the hospitals in Lisbon, Portugal, for children from three to ten years old who are suffering from protracted chronic diseases such as tuberculosis of the bones or rickets.

The school, which was established through the efforts of one of the physicians, is maintained by private contributions. The Government has given it the standing of a public school. Two teachers, graduates of a normal school, are in charge.

In addition to suitable theoretical instruction, the children are taught manual work, singing and drawing. Motion pictures and other entertainments are also provided.



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FOOD SERVICE AND EQUIPMENT

A Series by KATHERINE MITCHELL THOMA, Dietitian, AND HERMAN SMITH, M.D.,
Superintendent, Michael Reese Hospital, Chicago

Planning the Menu and Preparing and Distributing the Food

IN THE first two articles of this series we outlined the general functions and status of the dietary department in the hospital and certain details regarding the organization of the budget. In this article we shall attempt to discuss: (1) menu making on a budget basis; (2) food preparation and distribution; (3) inspection.

When the budget has been established, the dietitian has a sound basis for planning menus for the various types of patients and personnel. At this point the dietitian and administrator must cooperate in determining the general policy to be followed with regard to the types of menus to be served. Whether one menu is served to both ward and private patients and to all personnel, both staff and domestic, is immaterial, so long as the policy is definitely laid down and can be easily followed. Details of menu making have no place in this article and will not be discussed. It should be mentioned, however, that there should be a definite correlation between the various menus, if there is more than one, in order to assure the economical purchase and easy preparation of food.

Obtaining Helpful Criticism

That the menus may include as wide a variety of food as is possible and that temporary economies of purchase may not be overlooked, it is necessary for a close contact to be maintained between the dietitian and the person responsible for food purchases. Insofar as is possible, the dietitian should actually accompany the purchasing agent to market in order to keep in touch with current conditions.

The menus, or their end products, the food actually served to patients, should be the constant subject of objective criticism by both the dietitian and the administrator. Criticism in general should be of two types: (1) from the point of view of

the patient or the employee eating the food; (2) from the point of view of cost. The reaction of the patients to the food can usually be obtained in one or all of four general manners: (1) daily interviews of patients by dietitians or assistants; (2) inquiries from the staff and the nursing supervisors; (3) visiting committees of women's boards or women's auxiliaries; (4) follow-up letters to discharged patients.

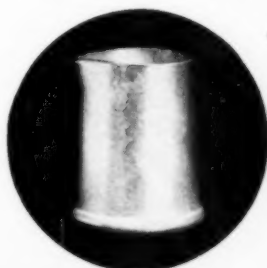
The Best Criterion—The Patient's Reaction

The dietitian or some member of her department should visit each patient as nearly as possible once a day. In organizations where the personnel is not sufficiently numerous, visits may have to be made as infrequently as twice a week. In every instance, however, some routine contact between the dietetic department and the patient should be maintained. By this contact, the dietary department learns the patient's choice of food and, because of this fact, is frequently able to obviate or forestall difficulties that otherwise might ensue. In spite of all precautions, a certain amount of dissatisfaction must occur in every organization, but through these routine contacts between the patient and the dietetic department difficulties are often cleared up immediately. They do not remain in the patient's mind as an ever increasing grievance and frequently are completely forgotten by the time the patient is ready to leave for home. This is in contrast to a belligerent attitude which can be developed by patients against the entire hospital because of uncorrected and really unknown food difficulties.

Inquiries addressed to members of the medical staff and supervising nurses by both the dietitian and the administrator concerning the general or individual reaction of patients to food will occasionally bring to light situations which, for one

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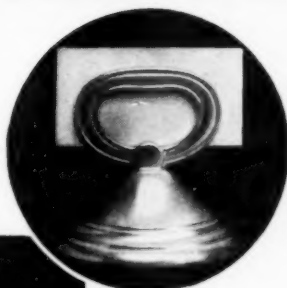


COFFEE POT 014733 WITH SPOUT

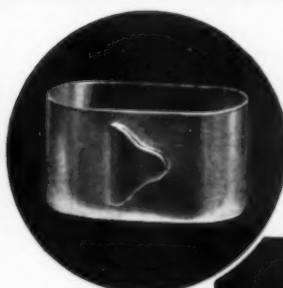


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reason or another, have not been reported to the dietitian by the patient. These inquiries have the additional function of engendering a better feeling of esprit de corps between the medical staff and the dietary department, and between the nursing staff and the dietary department. In this way both of these groups are made to feel that the dietary department is actually interested in something more than the preparation of food and its being handed to the patient. They learn that the department is actually interested in the patient's reception of this food and is anxious to know wherein it fails. Such inquiries are a means of asking for additional information from persons who come in close contact with the patients; they obviate any possibility of a "holier than thou" attitude between departments.

In certain organizations that have women's boards or women's auxiliaries, it has been found valuable to have properly personneled committees act as standing committees on inspection for the food of both patients and personnel. Members of these committees should actually eat the various foods under service conditions. This brings in an outsider's opinion of the quality and preparation of food and is more likely to approximate the community's thoughts upon food. It serves a double purpose. If there are legitimate complaints about food, the cooperation of this committee should be helpful in correcting it. If in the opinion of the committee the food is well prepared, it serves to counteract untoward comment about the hospital dietary. This is equally true of both the patients' and the personnel's food.

Benefiting by Outsiders' Opinions

At this point, it might be appropriate to stress the relation of the community to those hospitals which really are or should be community projects. The opinions of visiting committees from women's boards are of value to the hospital administration and its personnel, and to the community. As each has something to offer to the other, the contact should be of mutual benefit if both groups will be open minded and objective. The administrator and dietitian should look for and expect both constructive and destructive criticism from these groups. If no criticism is forthcoming, the group is a useless one. Likewise, if only destructive criticism is forthcoming the group is, by the same token, the wrong group. There should be a definite feeling that it is a problem to be solved, a task that should be undertaken in a spirit of mutual cooperation. If dietitians and administrators will utilize this force in its proper way, decided benefit should result.

Many hospitals have found the sending of form

letters to discharged patients valuable. These letters, irrespective of their wording, ask for criticism of the service, and frequently stress the question of food because that is one of the phases of hospital service, often one of the only phases of its functions that patients are capable of judging. Most organizations usually destroy or merely file commendatory letters because they are usually valueless. The critical letters are the valuable ones. In addition to investigating the criticisms set forth, detailed answers concerning the complaints should be forwarded to the writers. It is obvious that in most communities these form letters will soon be recognized as routine in the minds of the patients receiving them. This cannot be helped, but if no definite answer is received concerning specific criticisms, the community will soon lose faith in the sincerity behind the letter.

The Dietitian's Responsibility

The food served to the patient is the dietitian's responsibility. It seems only logical, therefore, to turn over to her the supervision of every step in its progress from the receiving clerk to the patient. The quality of food supplies received and every process in connection with preparation should be under the direction of the dietitian. If this is to be done properly, her department should be in charge of the general kitchens.

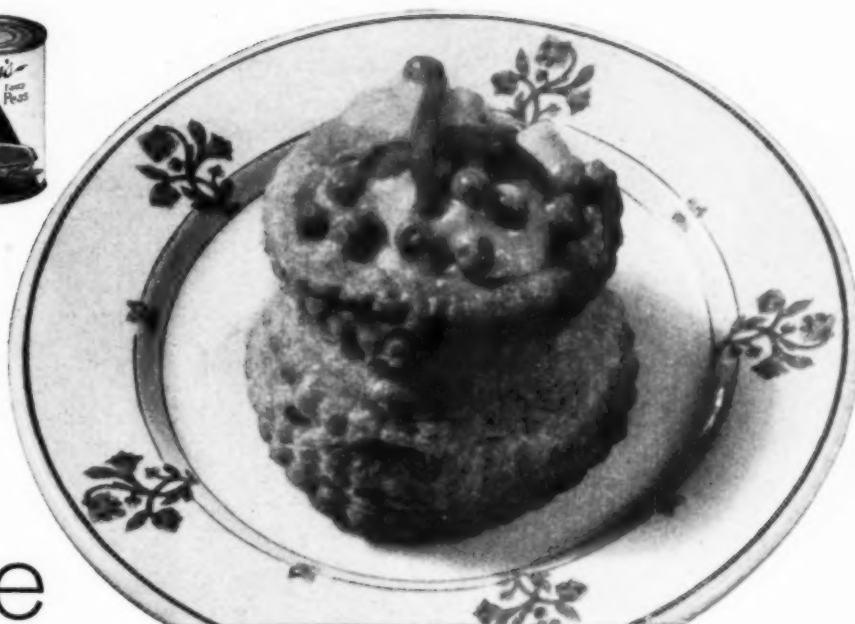
In the distribution of food to patients, there are two general types of conditions: first, the hospital in the blue print stage and, second, an existing institution.

The need of cooperation between the dietitian, the administrator, the architect and the consultant, if there is one, regarding the food layout and particularly the food distribution system, has been stressed too frequently to need additional emphasis. In planning a new hospital, members of the group would be definitely remiss in their obligations if they committed themselves to one system of food distribution. The planning administrator and dietitian may be committed to one system, and, while it is perfectly proper that they recommend the introduction of this system of food distribution, they should be broad visioned enough to realize that future administrators may wish to utilize different methods of food distribution and should therefore provide the physical means for a variety of systems. This should, in general, include dumb-waiters, service elevators and steam, plumbing and electric outlets.

There are, in general, three basic types of food distribution: central service; food cart service; reheating in floor pantries. There are almost numberless modifications of each of these systems. The tendency at present seems to be in favor of the

For the Convalescent Diet

Creamed Peas and Shrimps in Patty Shells. Add Libby's Peas, drained, and shrimps to a medium white sauce. Heat to simmering point, and fill patty shells. Garnish with strips of pimiento



Here's where the joy of eating comes in..

*Your patients, your
staff will notice it*

It's as true with your patients as it is with your staff—there's a feeling that meals should be pleasant.

What makes the difference between really interesting meals and commonplace food is just such dishes as these—every one of them a treat, appealing to eye and appetite.

Because they're based on Libby's Corn, Peas and Stringless Beans, they have just the qualities that make eating a joy. Succulent tenderness, natural flavor and color, all retained to the fullest.

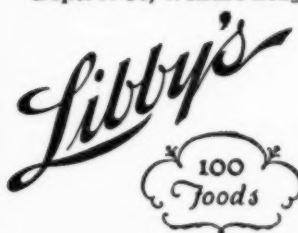
Libby's Vegetables, carefully selected, are sealed in cans within a few hours after picking. Then they're *Pressure-Cooked* by steam. In this way are preserved their natural nutritive value, vitamins and minerals.

These dishes, too, are distinctly economical. For Libby's Vegetables come *full-measure* to the can. Libby's is the *uniform pack* that means a *uniform cost* for every portion served.

Order from your usual source! Stringless Beans, Green or Wax. Corn, Whole Kernel, Cream Style. Peas, Early June or Sugar Variety.

Libby, McNeill & Libby

Dept. N-34, Welfare Bldg., Chicago



These Libby Foods of finest flavor are now packed in regular and special sizes for institutions:

Red Raspberries
Tomato Purée
Corn, Beets
Hawaiian Pineapple
California Fruits
Spinach, Kraut
Jams, Jellies
Pork and Beans
Tomato Juice

Olives, Pickles
Mustard
Bouillon Cubes
Beef Extract
Peas
Catchup
Chili Sauce
Salmon

Evaporated Milk
Mince Meat
Boneless Chicken
Stringless Beans
Santa Clara Prunes
in Syrup
Strawberries
Loganberries
California Asparagus

Special Luncheon Dish

Stringless Beans, Français. Drain Libby's Stringless Beans, and add finely chopped onion. Pour into individual baking dishes, and heat in oven. Top with 2 strips of broiled bacon, and garnish with sprig of parsley



For the Staff

Corn Fritter Luncheon, or Supper. Add Libby's Corn (Whole Kernel or Cream Style) to fritter batter (1½ cups of Corn to 3 cups of batter). Fry in deep fat and serve with Libby's Vienna Sausages, hot. Serve with syrup



first two systems and definitely away from the third because it has many definite and obvious defects. These defects have been discussed too frequently in the literature to need repetition here. Most of the modifications of the first two systems are sound and work out reasonably well. Any well thought out system wherein all details are included, from the preparation of raw food through its service to the patient and the subsequent cleaning and storage of utensils, will usually work out satisfactorily.

What the Administrator's Cooperation Means

Irrespective of the system of distribution decided upon, the supervision of this system should be under the direction of the dietitian. The actual service of food to patients, including the set-up of the patients' trays, even if this takes place in the floor duty room, should be under the supervision of the dietitian. All the personnel who have anything to do with this service, including pupil nurses who may set up trays, should be, during this function, under the dietitian's direction. With the proper cooperation between the superintendent of nurses and the dietitian, a smoothly working organization is usually possible. The necessity of the dietary department's being responsible for the actual service of the food to the patient is too obvious to need great explanation.

It would seem incongruous to have the dietary department responsible for food through every process up to the most vital step, the actual serving of food to the patient, and then turn this over to the nursing group who is not primarily interested in this duty or competent to perform it. Nurses have many functions to perform for patients. The handling of food is, in reality, a minor part of the care of the patient from the nursing viewpoint. While nurses may profess great interest in this function, their major work lies in many other directions. The dietitian's sole professional interest is in food.

At this point, there should be emphasized the need of a definite understanding between the dietitian and the administrator as to adequate personnel for the detailed supervision of food service. While not a necessity, it is usually advantageous to have the dietitian in charge of the personnel in the floor diet kitchens. This links up the dietitian's control of food service with the equipment necessary for the proper service. When the responsibility for the floor diet kitchen is in the hands of either the nursing or the housekeeping department, it is difficult to hold the dietitian responsible for the actual appearance of the tray as it goes to the patient since she is not responsible for its equipment.

Under this heading, one should consider two types of inspection: daily food rounds and weekly kitchen and dining room inspection.

"Daily inspection" refers almost entirely to the administrator, since it is taken for granted that food and food departments are constantly inspected by the dietitian. Insofar as possible, the administrator should make a daily inspection of all serving pantries and personnel dining rooms. Circumstances may interfere with these inspections, but for this most important duty the administrator should set aside a definite time and should not allow other duties to encroach upon it. These inspections should not be to consider the minutiae of the various places visited. They should be more in the manner of visits and observations of the actual working of the food distribution system. In this manner, the set-up of trays and their actual start to the patient can be easily seen. Proper contact is made with the dietary and nursing personnel and, if the right spirit is fostered, minor difficulties can be settled immediately and what otherwise would be annoying situations completely obviated.

Through these constant inspections or visits the administrator becomes completely familiar with the details of the food system and from his own first-hand knowledge can discuss its end results. These inspections bring him in contact with the dietary department and allow him to meet the supervising nurses more frequently than is possible with only detailed ward inspection. They provide for an easy and rapid solution of minor nursing difficulties. Perhaps of greatest importance to the administrator is the fact that the inspection makes all the personnel realize that the administrator is not someone who sits at his desk and gives orders but that he goes throughout the hospital at frequent intervals, that he is not only familiar with the detailed workings of the hospital but that he also has a sympathetic understanding of the problems involved.

Weekly inspections of kitchens and dining rooms will be discussed as part of the next article.

How Bureau of Blood Donors Will Aid Milwaukee Hospitals

Milwaukee hospitals are to benefit by a recent action of the Medical Society of Milwaukee in establishing a bureau of blood donors. The laboratory work of typing the blood and testing it is to be done by the hospitals. The donors are then registered with the bureau, which finds them immediately when a hospital calls for their services.

An IDEAL HOT DRINK

to help patients to sleep

PATIENTS who are confined to bed, often have difficulty in going to sleep easily and naturally at night. In these cases a cup of Kellogg's Kaffee Hag Coffee will be of real assistance.

Hot and cheery, this "coffee that lets you sleep" not only soothes and relaxes the stomach and induces slumber but it also has a beneficial effect on the patient's morale.

No possible harm can result from recommending Kellogg's Kaffee Hag Coffee. Because the effect of the harmful drug caffeine is removed. Yet all the fine flavor of the coffee is retained.

Kellogg's Kaffee Hag Coffee is especially valuable, too, in cases of neurosis when ordinary coffee must be prohibited.

It is guaranteed pure coffee—97% free of caffeine, and also has the indigestible wax removed.

Write to the Kellogg Company, Battle Creek, Michigan, for a generous free sample of this fine coffee. We want you to taste for yourself the new improved blend that is indistinguishable in flavor from the most expensive coffees sold today.

. . .

KELLOGG COMPANY, Dept. R-1, Battle Creek, Michigan

Please send me, free, a 1/2-pound can of Kaffee Hag Coffee. (Offer good in U. S. A. only.)

Name _____

Address _____



Kaffee Hag Coffee is accepted by the American Medical Association. It is often recommended by physicians.



HOSPITAL EQUIPMENT AND OPERATION

Conducted by C. W. MUNGER, M.D.
Director, Grasslands Hospital, Valhalla, N. Y.

How to Buy Equipment

BECAUSE of the fact that the hospital has been less affected by the present economic depression than most other fields, a rapidly increasing number of merchandisers are now endeavoring to "sell" hospitals. Unfortunately, many of them are not familiar with hospital standards and, as a consequence, are making extravagant claims about products that are often inferior.

In view of price readjustments now being witnessed in nearly all lines of commodities and supplies, it is important that hospitals use care in making purchases. Lower prices can logically be expected to-day, but some caution must be exerted in determining values for prices paid. In a word, it is always wise to be skeptical of price cutting tactics on the part of dealers and manufacturers. Economies are to be measured not solely in terms of original investments but by determinations as to the eventual utility of products in the institution.

Most buyers to-day are price conscious. And for good reasons. With incomes somewhat reduced, with budgets trimmed to a minimum, the executive is forced to realize more for his expenditures. Newspaper accounts tell of lower raw material costs. Salesmen offer added cuts and discounts. Competition for sales is more keen. And with a rapid increase in the number of concerns that have deserted less remunerative markets to capitalize the hospital, there is danger that unfair claims and unjustified low prices will become prevalent and will confuse intelligent standards of purchasing.

Some Dangers of Careless Buying

Quite obviously the hospital cannot take part in any attempts to save money at a sacrifice of quality and utility. To gamble with inferior merchandise and to deal with manufacturers of unknown integrity involve too great a risk. Interruptions in hospital service are dangerous. Equipment and supplies must be serviceable above all, and only

after you are convinced that they are serviceable can you consider the price factor.

Intelligent purchasing practice contemplates a judgment of quality in relation to price—and quality comes first. You buy any product to have the benefit of its service to you. If you can do so at a low cost you are justified—if you are also assured that service is not sacrificed.

What the Buyer Must Consider

The intelligent buyer, besides the factors of quality and price, always considers the following:

1. Who is the manufacturer? What is his experience with hospitals? Is he a recognized vendor, identified with the field?
2. Has the product been designed for hospitals? Does it answer the exacting requirements of the field? Has it been tried and proved in hospitals?
3. Is the product standard? In other words, will it fit in with the layout or makeup of your institution?
4. Will the product offer continuous efficiency? Is it an established and accepted item or an experimental novelty?
5. Will the original investment be followed by further costs for maintenance? Will repairs have to be made and parts replaced from time to time? If so, is there assurance that such parts will be available in the future?
6. Is the product identified by trade mark? Is it completely manufactured by one concern or is it assembled? Has the seller control over replacements and parts?

7. Will you receive a guarantee of service as well as quality? Will the manufacturer protect you against inherent faults that might necessitate later costs on your part?

Investigations of such questions, often overlooked, will reveal many points of value or lack of value.

The standardized product, of course, is the one that is usually safest to purchase. Quality that has

With these films your X-ray Department

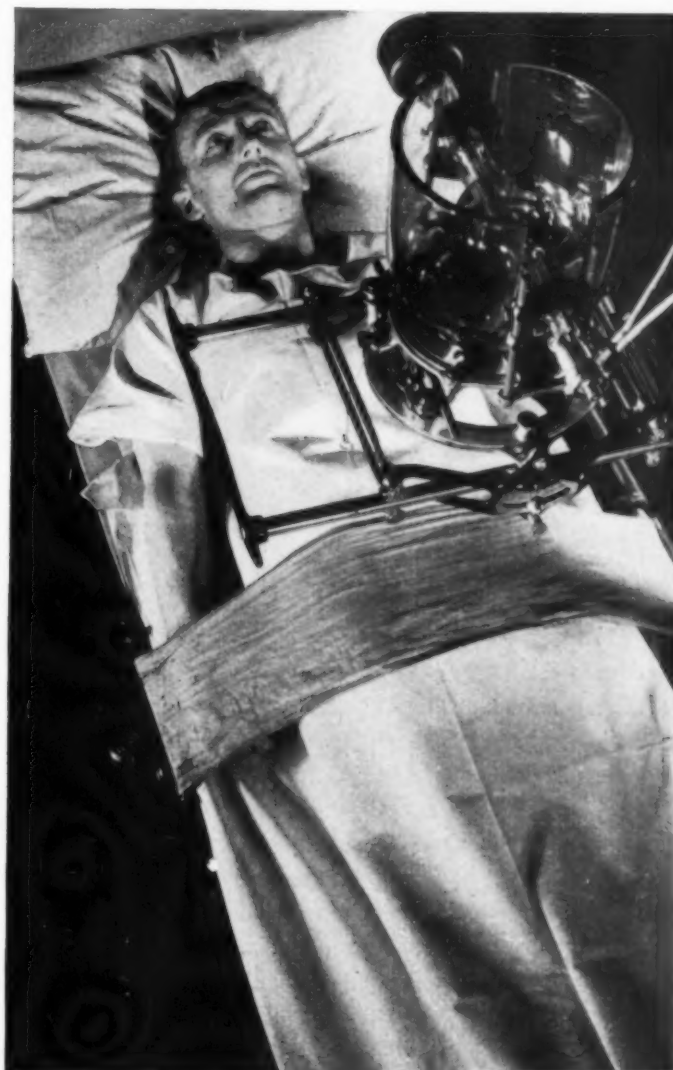
—Functions Efficiently

—Curtails Expenses

MEMBERS of the hospital staff today turn more frequently to the radiologist for diagnostic assistance. They realize the value of radiography in quick, positive diagnoses. Thus the x-ray department becomes increasingly important in modern hospital routine.

Since maximum service must be rendered in the shortest possible time, and with minimum cost, the choice of x-ray film must be made with efficiency and economy in mind.

With Eastman *Ultra-Speed* and *Dia-phax* Films, today's demand for radiologic service can be handled effectively and economically. Radiographs of superior diagnostic quality can easily be



obtained, for these films are extremely sensitive. They record diagnostic detail accurately and reduce the number of retakes, thus saving equipment from unnecessary use. Furthermore, their uniformity facilitates standardization of procedures in both the exposure and the processing room.

EASTMAN X-RAY FILMS

*the Accepted Radiographic
Media the World Over*

EASTMAN KODAK COMPANY, Medical Division,
343 State Street, Rochester, N. Y.

Gentlemen: Please place my name on your mailing list for the free bi-monthly magazine, "Radiography and Clinical Photography" published in the interest of better radiography and photography.

Name

Institution

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This NEW Service to
Mother and Baby
builds Good-Will for Your Hospital

Dennison's
BABYPADS

Reg. U. S. Pat. Off.—Patents Pending
 THE NEW SANITARY DIAPER LININGS

INEXPENSIVE
EFFECTIVE
LABOR-SAVING



EVERY new mother appreciates a service to her baby—especially when this service is one that shows her not only how to protect baby's health and comfort, but also how to save her own time and energy. You can render such a service, at trifling cost, through the use of Dennison's Babypads.

Babypads are sanitary diaper linings, made from downy-soft, specially prepared material. They fit inside the regular cloth diaper, protecting it from customary soiling and eliminating unpleasant handling of soiled diapers. Because they retain their strength when wet, Babypads may be removed intact after a bowel movement and flushed down the toilet.

Mothers will be glad to learn of this new sanitary protection for their babies through seeing Babypads used in your hospital. They will thus learn to safeguard their babies against risk of painful diaper irritations, frequently caused by impurities (uric acid, soap alkalies) which may be retained in cloth diapers after washing.

Babypads will eliminate several operations from the handling of soiled diapers...will save a needless drain on your nurses' time. And they are so inexpensive (the Hospital Package of 1,000 costs only \$2.50) that you can well afford this service to your patients...this convenience for your nurses. For further details, write to the Dennison Manufacturing Company, Dept. N-9, Framingham, Mass.

LARGE PACKAGE FREE—Send Coupon

If you have not already seen and used Babypads, send the coupon for a free demonstration package which will enable you to give them a trial.

DENNISON MFG. CO., Box N-9
 Framingham, Mass.

Please send me, without charge, a demonstration package of Dennison's Babypads.

Hospital.....No. of bassinets.....

Address.....City.....

Your Name.....

© 1931 and 1932, by the Dennison Mfg. Co.

been built up, established by advertising and the acceptance of hospitals, is always worthy of first consideration. Here you have the manufacturer's assurance of value, backed by his integrity and willingness to give an honest statement of his wares. He is striving for recognition. His policies are based on a conscientious desire to become an important factor in the field. In a word, he has identity and generally will sell on an honest basis to safeguard his reputation. The "unknown" manufacturer does not have so much at stake. He is far more likely to resort to unethical practices, for he is more concerned with immediate profits than with any permanent friendship among hospitals.

Examples of illogical buying procedures are numerous, in spite of the fact that the field at large is noted for its high standards and ability to measure values.

How One Hospital Learned by Experience

A hospital in Indiana, for example, accepted plumbing fixtures "of equal value" to the original specifications of the architect. The initial saving ran into a sizeable figure. However, here are a few of the troubles that quickly resulted. Vitreous fixtures were found to be of low quality. Whenever a toilet or lavatory broke, it was necessary for the hospital to tear out the wall and build new supports—because the fixtures were neither standard nor identified by trade mark. Valves throughout the building, likewise, could not be identified. The plumbing contractors could not locate sources of supply. The valves had been supplied by a jobber who had purchased them in a "job lot" sale. Replacement parts could not be found. In consequence, entirely new valves had to be installed, causing serious interruptions to service and much extravagant expense.

Stories of this kind could be told endlessly. In some cases there is definite evidence of misrepresentation on the dealer's or manufacturer's part. However, the main source of error usually rests with the negligence or carelessness of the person who does the buying.

Questionable Economies

If new conditions to-day call for emphasis on economy, more careful attention will have to be paid to measurements of quality. Generally a cheap product either lasts for a shorter period of time or requires more expense in maintenance than a more expensive product. Thus, while the first cost may be low, the factors of utility and service may also be low. Perhaps in some instances economies can be bought cheaply. But as a rule cheap merchandise creates added demands on the time and patience of your personnel—costs that must be reckoned by the careful buyer.



ARCHITECTS
Coolidge, Shepley, Bulfinch
and Abbott
— Boston —

ENGINEERS
Jas. A. Cotter Co.
— Boston —

FIXTURES
Standard Sanitary Mfg. Co.
— Pittsburgh —

JOBBERS
Dimock and Fink
— New York —

PLUMBERS
John McMillan Co.
— New York —

New York Hospital, Cornell Medical Center Equipped throughout with SLOAN FLUSH VALVES

Why have Sloan Flush Valves attained such amazing popularity?

In what respect do they differ from any other valve which will flush a fixture?

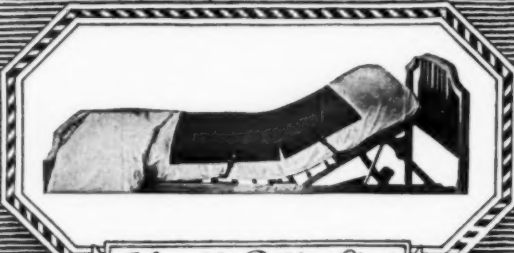
The answer is to be found in twenty-five years of specialization by men who know their business. Manufacturing flush valves *exclusively*, the Sloan organization has acquired a knowledge of flush valve requirements and a breadth of flush valve experi-

ence which are unique and unapproachable.

This wealth of knowledge and experience has been applied to furnish a *flush valve for every hospital purpose*—today the Sloan line provides for the specific needs of any installation most accurately and economically.

The vast majority of hospitals have discovered this truth. Others are invited to make comparisons and satisfy themselves of the certainty of Sloan superiority.

SLOAN VALVE CO • CHICAGO



Norinkle Rubber Sheets

RECOMMENDED
By All Who Use Them

We are confident that you, too, would recommend Kaufmann's NO-RINKLE RUBBER SHEETS after you used them. They are the most economical, most satisfactory method of mattress protection obtainable. Now being used in hundreds of hospitals. Write for descriptive folder. No obligation.

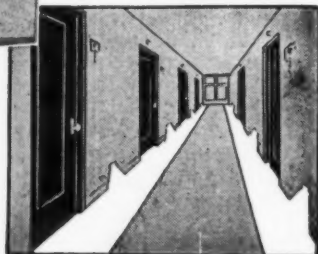
HENRY L. KAUFMANN & CO.
301 Congress St., Boston, Mass.

Save! with this new lighting

The Louvre Lite

*A Night Light
for Corridors*

FLUSH to the Wall.
Sturdy — Durable,
Inconspicuous. Very
efficient, economical
floor illumination.



*Write for literature just off the press,
describing more fully.*

THE CHICAGO SIGNAL COMPANY

Pioneers in the Manufacture of Silent Call Systems

312-318 S. Green St., Chicago, Ill.

All purchases should be made in the light of service desired. The ideal should be to maintain a consistently high standard, keeping in mind the duty of the hospital and its responsibilities to its patients.

Combination Bedpan Washer and Sterilizer Is Perfected

There has recently been placed on the market a combination bedpan washer and sterilizer that is adapted for recessed or built-in installation. Several years have been devoted to the perfecting of this apparatus, with a view to overcoming certain generally known objectionable features. It is now being offered to hospitals under the guarantee that it will wash and sterilize a bedpan, that there are no parts of the apparatus that are liable to require constant renewal and that the door



This bedpan washer not only washes and sterilizes the bedpan but eliminates many disagreeable features of the procedure.

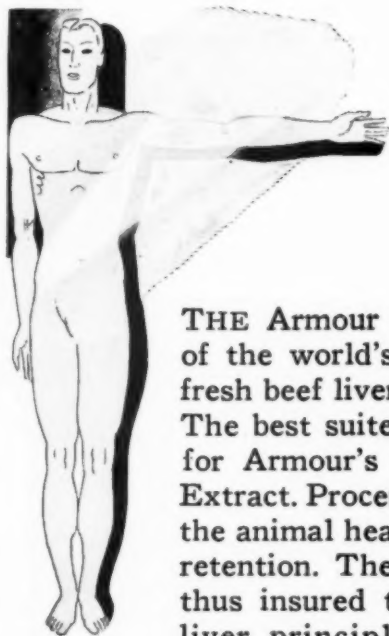
when closed is water-tight, steam-tight and odor-tight.

Bedpan technique in every hospital for some reason always presents a live topic of discussion. Many ingenious and more or less efficient bedpan washers and sterilizers are offered by manufacturers all with a view not only to washing and sterilizing the bedpan but to eliminating the disagreeable features of this routine duty. Whether it is better or quicker to handle bedpans in a combination washer and sterilizer or in a separate apparatus for each purpose appears to be still a matter of discussion.

MAXIMUM AND UNVARYING POTENCY

Armour's

Concentrated Liver Extract (LIQUID)



THE Armour Laboratory has one of the world's largest supplies of fresh beef liver to draw upon daily. The best suited of this is selected for Armour's Concentrated Liver Extract. Processing is started while the animal heat is still in a state of retention. The finished product is thus insured to contain the fresh liver principles active in blood regeneration.

Armour's Concentrated Liver Extract is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. Each 16-ounce bottle contains the soluble extractives of eight pounds of fresh beef liver.

• • •

Besides producing a complete line of organo-therapeutic products, the Armour Laboratory manufactures fine surgical ligatures of selected sheep gut. The facilities of the Armour organization make immediate processing possible. Armour's ligatures retain their uniform elasticity and strength, and are evenly absorbed. Samples will gladly be sent you.

ARMOUR AND COMPANY

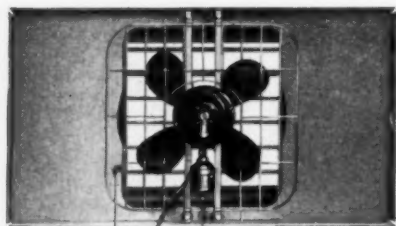
Chicago

"Headquarters for medical supplies of animal origin"



Armour's Concentrated Liver Extract is remarkably beneficial in the treatment of pernicious anemia. A tablespoonful is the equivalent to four ounces of fresh liver.

Draws out all odors *quickly quietly*



from operating rooms,
kitchens, laundries,
lavatories, wards, etc.

The Signal Window Ventilator requires no servicing—easy to install—adjustable and removable—fits snugly into window—Induction motor does not interfere with radio reception—quiet in operation—low in operation cost—French grey finish—price \$18.00.



Where a ceiling fan is preferred, Signal Junior 20-inch Ceiling Fan will meet your requirements—displaces 1600 cu. ft. of air per minute—list price \$26.00.

If your supply jobber does not have the Signal Window Ventilator or Junior Ceiling Fan, write direct to

SIGNAL ELECTRIC MFG. CO.
Menominee, Michigan

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SERVICE

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LINE

COMPLETE-PLUS!

A "he-man" Message Clip. A matching Card and Message Holder. Radium Luminous Treatment where desired. Any color scheme or finish. 50 sizes—Single or double faced. No other line is half so complete.

Catalogue, Samples and Quotations on request.

U.S.R. PRODUCTS DIVISION
UNITED STATES RADIIUM CORPORATION
535 PEARL STREET, N. Y. C.

The combination washer and sterilizer, providing it is efficient for both purposes, appears to afford the best answer to the problem and assures economy in first cost. If, however, a separate sterilizer is preferred, it can be supplied with a capacity of five bedpans and a standard rack, and a choice is offered of sterilizing with live steam discharged into a nonpressure container known as a bedpan steamer or by the method of boiling water.

The company that is offering the combination apparatus has for many years made a bedpan washer and sterilizer, hopper type, which has gained favor with a great many hospitals in this country and Canada. Many hospitals have installed as many as twenty-five or thirty. This apparatus differs from all other types in one important respect—that is, it delivers water and steam immediately on the surface of the bedpan through separate jets connected to the bedpan rack. Cultural tests show a complete sterilization of a clean pan in thirty seconds.

"Balanced Drive" Is Feature of Newly Perfected Washer

Much interest has been aroused among the laundry industry by the introduction of a new washer which was exhibited for the first time at the recent convention of laundry owners in Louisville, Ky.

Outstanding among the numerous features of the new machine is the "balanced drive" principle, which is unquestionably an engineering achievement. Other features include: silent running, with an absence of vibration; heavier metal gauges and frames; elimination of overhead structure; precision machine construction; segregated timer control, and high gear ratios.

"Balanced drive" is a fundamental principle of equalizing pull or drive, but it is new in its application to laundry equipment. The drive may be illustrated by comparing it to the whiffletree of a wagon or the differential of an automobile. Each is used to equalize or to balance the transmission of power. In the new drive, equal drive is obtained at both ends of the cylinder, thereby eliminating strain and wracking and ensuring equal wear of the two pinion gears. Also, any flexing of the shaft, due to torque, is instantly taken up so that both gears must drive uniformly. The unit consists of two "equalizers" (differentials) built into a driven shive. These equalizers are free to move in housings which are keyed to the drive shaft. The shive, or pulley, is driven by multiple cog belts.

There is no super structure. By eliminating the intermediate shaft, it has been possible to reduce

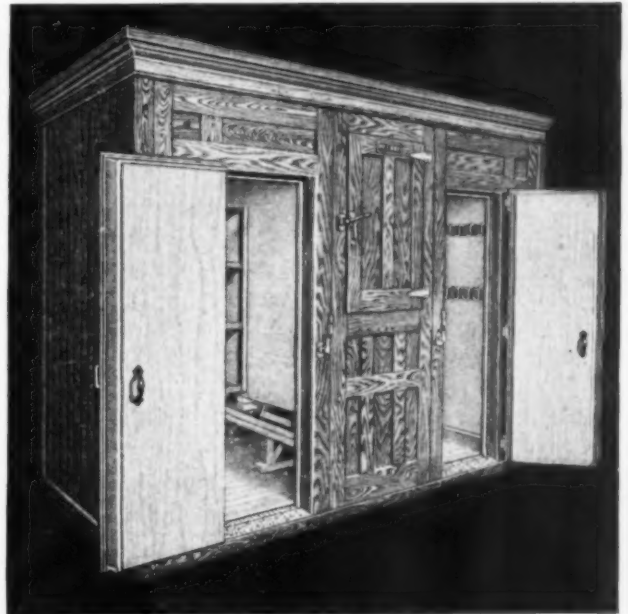


The gaunt plateau that turns the course of the Yssel river sharply northward also changed the course of humanity. For, here, on the lonely heath that surrounds Deventer, toward the end of the fourteenth century the young man Gerard Groote was accustomed to wander, a dog and a book his only companions.

Out of the solitude of the "Barren Meadow" came ideas that were to result in a momentous religious movement and revival of learning that was soon to spread over Western Europe and to be carried into the New World. Though he himself had no active part in Nursing, as founder of the Brotherhood and Sisterhood of the Common Life, Groote strengthened the arm that held the torch of Service high in a trying period.

WILL ROSS, INC., WHOLESALE HOSPITAL SUPPLIES
779-783 No. Water Street Milwaukee, Wisconsin

A McCRAY COOLER for General Storage



McCray cooler No. 171 is 10 feet wide, 5 feet deep and 8 feet high.

TO KEEP reserve stocks pure and wholesome in their original freshness and flavors, McCray model 171 affords generous storage space and thorough refrigeration in every compartment. Efficient in service because soundly built with McCray quality materials and McCray craftsmanship in every hidden detail. Compartment at right is equipped with shelves, meat rails and hooks; compartment at left has shelves.

Remember, there are McCray refrigerators for every purpose—styles and sizes to meet your particular needs. Send coupon now for catalog and details; no obligation.

Salesrooms in All Principal Cities. See Telephone Directory.

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REFRIGERATORS

ALL McCRAY MODELS
MAY BE USED WITH
MECHANICAL
REFRIGERATION OF
ANY TYPE

McCRAY REFRIGERATOR SALES CORPORATION
266 McCray Court, Kendallville, Indiana

Gentlemen: Please send
catalog and information
regarding [] coolers;
[] storage refrigerators.

Name _____
Street _____
City _____
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FROM ONE DOCTOR TO ANOTHER



**"SO MANY BEDRIDDEN
PATIENTS NEED THE
BENEFITS OF ULTRA-VIOLET"**

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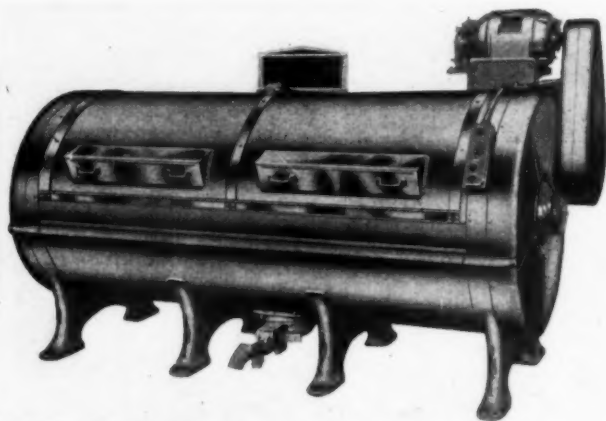
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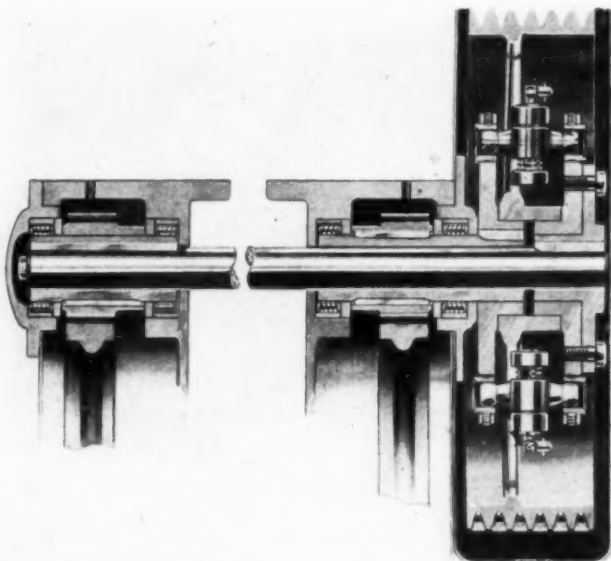
the number of gears from eight to four, thereby providing the advantages of lower frictional value; fewer bearings and working parts provide a lower maintenance factor.

The shell is of the "solid head" type. The sheets are of hard noncorrosive metal, riveted to the



shell heads. They are internally lead caulked and pressure sealed at the joints. This is a distinctive new feature to prevent shell leakage.

Still another outstanding refinement of the machine is the design of the trunnion bearings. These are mounted in a flanged housing and bolted directly to the machined seat of the shell heads.



A full view of the new washer is shown above while the lower picture is a cross sectional illustration of the balanced drive unit.

This ensures perfect alignment of the bearings and has the advantage of allowing the easy removal of the trunnions through the shell heads. The trunnion bearings are of the outboard type. Each is fitted with double automatic, spring actuated packing. Between this packing and the bearing there is a sump, or two-inch drain leading directly to the gutter. Thus, it is impossible for



Refrigeration at the Harborview Hospital, Seattle, is supplied with Frick CO₂ Equipment.

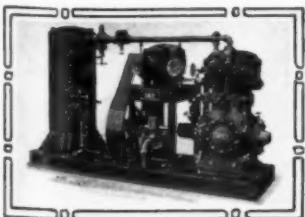
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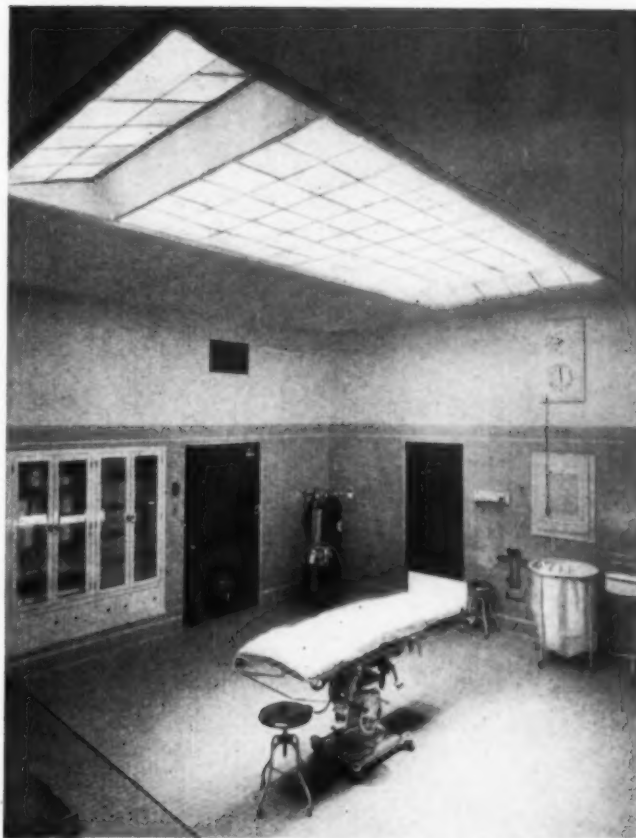


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Over a hundred fine hospitals, some of them in distant countries, are counted among the thousands of users of Frick Refrigeration. As builders of both ammonia and carbon dioxide equipment, with experience dating back to 1882, we can meet your requirements with full satisfaction, regardless of the size of your institution.

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scientifically adapted to every requirement of modern hospitals

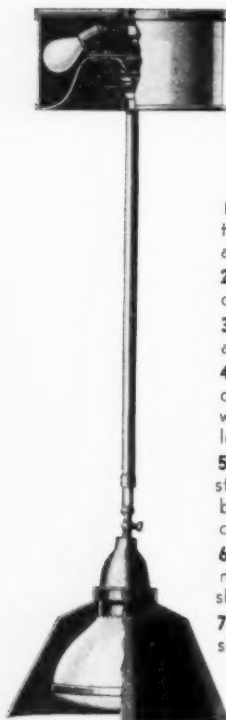
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Cross-section showing construction

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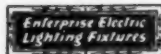
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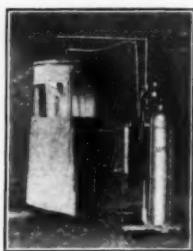


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the washing solution to reach the bearing, or the lubricant to find its way into the washing solution. The bearing, also, by its compact design, has the advantage of reducing the over-all length of the machine.

Another unusual feature is the cylinder latch. Both the latch bolt and the latch catch are interchangeable and reversible. This means that on each door, four adjustments of the latches can be made, a considerable lengthening of service from this unit. The latch housing is of hard, diepressed noncorrosive metal. The bolt is nickel alloy, tapered and automatic seating. The latches hold the doors rigidly closed but are exceptionally easy to operate.

In designing the cylinder of the machine for washing action, the engineers made exhaustive tests for speed, for rib arrangement, for rib height and for cylinder diameter.

The manufacturers have developed an extremely simple but ingenious dump valve. In one unit are enclosed the steam heating, water circulating and outlet features. Thus much of the customary piping and fittings is eliminated. The valve has splash guards in front and at the back to prevent the water from flushing out on to the floor. It is of the cam and roller type, operated by merely flexing the foot to open or to close and lock. Still another advantage of the machine is the magnetic brake which eliminates the conventional hand brake and gear locking device. This feature makes "spotting" of the cylinder doors exceedingly simple. The control for this is located in the control station mounted at the front of the machine. The cylinder may be inched up or down, started or stopped by depressing the control buttons. This brake is automatic and foolproof. The motor to which the magnetic brake is attached, is mounted on an adjustable platform to maintain the proper tension of the cog drive belts. The belts, as well as the main gear reduction, are enclosed in diepressed, copper molybdenum bearing steel guards.

Oxygen Tank Truck Has Variety of New Features

The accompanying photograph shows an oxygen tank truck that has been recently developed to meet the requirements of hospitals in New York City.

The truck is balanced so that it may be tipped from the vertical position back on to the rear casters or vice versa with a minimum of effort. When the truck is being wheeled, it rests on all four wheels and requires no balancing or holding.

The dimensions and specifications of the truck are as follows: It has an angle iron frame with

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WHEN an overwhelming majority of the hospitals under construction are installing Savory radiant gas Toasters . . . there must be something about this toaster that's better. And there is . . . it employs an *exclusive* toasting principle that first cooks the bread with moist gas heat . . . and then carmelizes the moist sugar on the surface with quick radiant heat. That's why Savory toast is so appetizingly different . . . with its crisp, evenly-browned surface and its fresh, soft center.

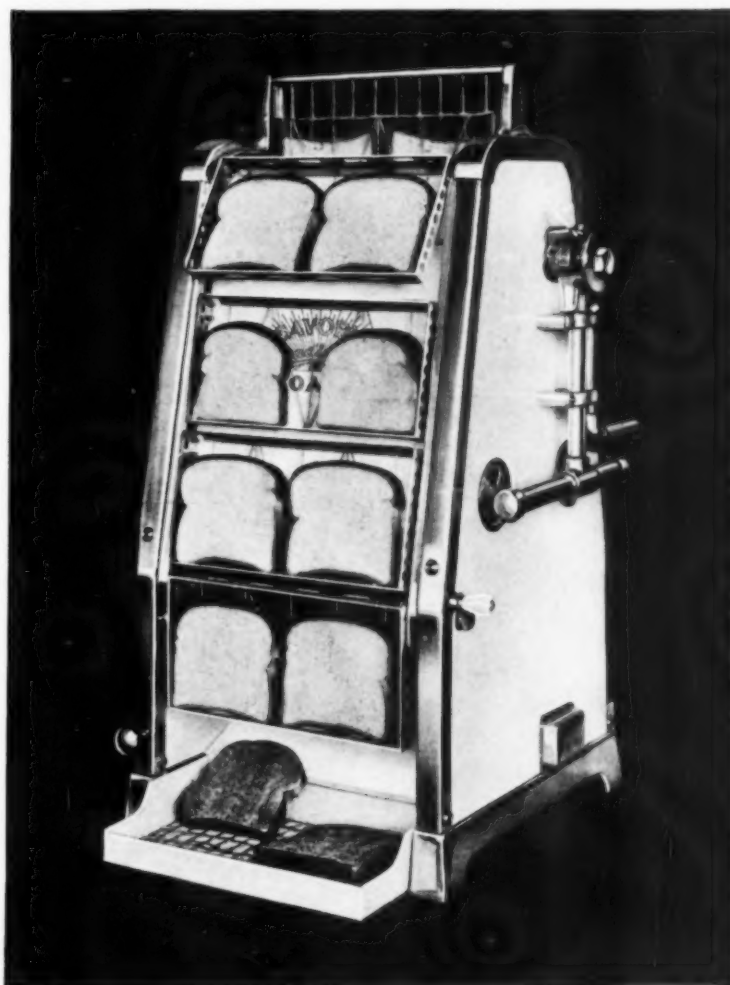
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And another reason for the growing preference for Savory . . . it's an automatic toaster that's *really* automatic. The nurse simply puts one slice or two dozen in the baskets for her patients . . . and picks up finished toast from the Savory as she leaves. While her toast was being made, other orders were started . . . because a Savory delivers the toast to the tray at the bottom. Nobody has to watch a Savory.

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Many hospitals now operating are replacing their present toast-making equipment with Savory Toasters. And no wonder. They make 180 to 720 slices an hour for only $\frac{1}{2}c$ to $4\frac{1}{4}c$. Let us send you the names of hospitals equipped with Savory Toasters and complete information about this new gas-fired, money-saving toaster. Just mail the coupon today.

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